PUBLIC HEALTH NURSING

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SHALL PUBLIC HEALTH NURSES HAVE A CODE?

Ever since the word "code" became a part of our national vocabulary, the question has been agitated in correspondence and conversation: Shall public health nurses have a code? Technically, social workers including nurses are exempt from the terms of the blanket code on two counts—they are employed by non-profit making agencies and are classified as professional workers. President Roosevelt in a recent address to social workers remarked humorously, "I want to tell you that you are hereby absolved from the N.R.A. If you want to work seventy hours a week, go to it!" However, the Code does apply to clerical staffs of social agencies and the N.O.P.H.N. has advised its corporate members to sign the Code for clerical staffs and has signed it for its own non-professional staff.*

It would be unfortunate if the words of the President were taken literally by public health nursing agencies. Indeed, the chance to use the Code as a weapon in the fight for shorter hours for private duty and institutional nurses was seized by the American Nurses Association and a trenchant statement issued in August showing how the Code and the spirit of recovery applied to working hours in these fields and the employment of nurses who were out of work.**

With this preamble we return to the question, Shall public health nurses have a code? Is there anything to be gained in our field by the adoption of a set of regulations governing hours of work, wages and charges for service? The actual situation seems to be that we have already what is virtually a code. N.O.P.H.N. studies have shown astonishing uniformity in hours of work, salaries, and charges for service throughout the whole country. Hours of work, particularly, have been adjusted to the capacity of the nurse and the demands for service and variations in salaries and charges are due usually to differences in the local costs of living. At no time (since public health nursing agencies are non-profit making) has there been "cut-throat" competition in this field or artificial price-raising. The consumer has received a generally high standard of professional service at cost or free. Doubtless the fact that public health nurses as a group have similar basic and required preparation for their jobs, and the fact that the N.O.P.H.N. has issued objectives, standards, techniques, minimum qualifications for positions in the field, as well as made detailed studies of costs, services and salaries, have tended to stabilize and lend uniformity to this commodity—public health nursing. Practically every public health nursing service of any size in the United States has turned at one time or another to the published statements of the N.O.P.H.N. For these reasons, it would seem that the effort to codify what has become accepted practice (or desirable practice to be put into effect when conditions allow) would hardly be justified at this busy time. So far as we can judge every agency is employing as many nurses and working on as generous a time and salary schedule as good service to the community permits, and the majority of agencies are struggling to restore the salary cuts of the last three years. In short, public health nursing, although exempt from adopting a formal code, has all the elements of a code and is, we believe, living up to the spirit of the President's Recovery Program.

*See PUBLIC HEALTH NURSING, September, 1933.

**This statement may be obtained from the A.N.A., 450 Seventh Avenue, New York, N. Y.

FREE WHEELING IN THE TUBERCULOSIS MOVEMENT

Steadily, for more than a quarter of a century, the number of deaths from tuberculosis has grown less. In 1900 the death rate from this disease was 202 per 100,000 population. This rate has declined on an average of about 4½ points each year so that in 1930 the rate was 71 per 100,000 population. Until the beginning of the depression this favorable trend was attributed by health officers mostly to a steadily rising plane of living of the American people. Other factors, of course, were given due credit, but what could be more logical than to assume that tuberculosis, a disease known for centuries to go hand in hand with poverty, should decline with the rise in wages, better housing, more abundant food and more leisure time?

But suddenly our prosperity buckled a wing or something, and spun off into the most desperate depression this country has ever seen. No wonder that from various quarters one heard the prediction that the tuberculosis death rate would rise. Actually a strange thing has happened. During the four years of depression, deaths from tuberculosis have continued to decline. There stands the record of the past four years. It gives us no inkling of what may happen in the future but it is a strange phenomenon. How can we account for it? Have our previous teachings been wrong or is there something unusual about this particular depression?

Of all the explanations offered the one which seems most probable is that the momentum of the tuberculosis movement has been carrying us through just as the free wheeling device on the auto enables the car to speed on for some distance with a minimum consumption of gas. How long the tuberculosis movement can continue on free wheeling no one knows. Certainly it cannot be indefinitely. In an emergency the American people can do great things. Health departments and sanatoria have continued to function with meager funds. Cheap food, low wages and the loyalty of employees have enabled them to do so. Some doctors and nurses have worked for nothing more than board and lodging. But that cannot go on. Sooner or later sanatoria if not properly supported will have to close their doors. The patients will be thrown back on their helpless communities soon to die. Well people compelled to live with them will be in danger of getting the disease. Without the watchful care of the public health nurse the control of the spreaders will relax and more disease will follow. And so with the other measures necessary to keep a controlling hand over tuberculosis. On an up-grade free wheeling is no good whatever.

Health is won by long-time planning. Tuberculosis does not kill immediately. Nor can it be kept down by occasional spurts of energy. Only by steady progress can we hope to overcome it.

For a tenth of the sum expended for treatment the program of tuberculosis prevention could be made many times more adequate. In just the proportion that preventive measures are stressed will the tuberculosis death rate be diminished, the number of active cases reduced, the length of illness shortened, and the productive and economic loss to the country minimized. If, during the annual Christmas seal sale conducted throughout the United States by the 2,084 tuberculosis associations, every individual 25 years of age and over bought only 55 cents worth of Christmas seals, there would be available $30,000,000 for tuberculosis prevention. It requires little mathematical training to appreciate the difference between a per capita cost of $.24 for *prevention* as against the totally unnecessary per capita cost of $2.42 for *treatment*.

H. E. KLEINSCHMIDT, M.D.,
National Tuberculosis Association.

Nursing Care to Those on Relief

As we promised in the November number of PUBLIC HEALTH NURSING we hasten to share with our readers the information which the National Organization for Public Health Nursing sent in November to its corporate members, the S.O.P.H.N.'s, the State Nurses' Associations, state supervising nurses and health officers of states where there are no state supervising nurses. This material concerned provisions for bedside nursing service provided in the home to recipients of unemployment relief, according to the policies stated by the Federal Emergency Relief Administration in "Rulings No. 7".*

The material sent out by the N.O.P.H.N. was an attempt to clarify and interpret the published statement called "Rules and Regulations No. 7"—from the F.E.R.A. Letters, telegrams and interviews from all over the country indicated the need for some such clarification. While this memorandum was in no sense an official document from the F.E.R.A., it is based on the N.O.P.H.N.'s contacts and conferences with members of the F.E.R.A. staff.

If further questions arise, which they undoubtedly will, the N.O.P.H.N. will continue to stand ready to try to find the answer and to be of any possible service both to relief administrations and to nursing agencies in carrying out the policies of the F.E.R.A.

I. *Wherein does the authority rest for putting Rules No. 7 into effect in states and localities?*

a. The F.E.R.A. in its printed statement has laid down the *policies* and procedures governing bedside nursing care in cases where the expenditure of Federal Emergency Relief Funds is involved. However, the statement is permissive and not mandatory and, therefore, rests back upon state and local relief administrations for adoption. However, the F.E.R.A. obviously considers medical care in the home, including bedside nursing, for unemployed families on home relief as an essential part of an adequate relief program. Also, in public statements—printed and spoken—Mr. Hopkins has made clear that the F.E.R.A. is going to do its utmost to see that adequate relief is provided the unemployed. Therefore, pressure may be brought to bear from Washington. But Rules No. 7 cannot be considered a mandate.

b. Administrative responsibility for putting Rules No. 7 into effect is decentralized and rests with state and local relief administrations. This means that requests for authorization of bedside nursing service in *families of the unemployed on public home relief* (and this is the clear limitation of the services that will be paid out of relief funds) should go direct from the agency to the local emergency relief administration and from there to the state if need be.

c. Local and state relief administrations make their own arrangements as to the extent of or the limitations of the service, as to the agencies used and the basis of payment, so long as these are not inconsistent with Rules No. 7. It is clearly implied in Rules No. 7 and from public statements by the F.E.R.A. staff as well as from the N.O.P.H.N. conferences with the F.E.R.A. that it is recognized that the most effective and economical way of providing this service is through the use of existing community agencies organized to give bedside service on a visit basis. These are usually visiting nurse associations.

II. *What funds are available to pay for medical care including nursing?*

a. No special money—federal, state or local—has been appropriated to pay for this care in the homes of the unemployed. Therefore it must be considered, and is so considered by the F.E.R.A. as part of the whole relief program and comes out of the total relief budget.

b. Just as pressure is needed for sufficient state and local appropriations to provide adequate relief in food, so pressure must be brought to bear to have the appropriations large enough to include medical and nursing care.

*Rules and Regulations No. 7 Governing Medical Care Provided in the Home to Recipients of Unemployment Relief. U. S. Government Printing Office, Washington, D. C.

III. *Local and state nursing committees.*

a. Rules No. 7 clearly says that state and local relief administrations *shall* request the presidents of the state and local nursing organizations to designate an existing committee or appoint a special committee, to advise them in the formulation and adoption of adequate programs for nursing care in the home for indigent persons. The relief administrations shall be responsible for the final adoption of such programs. The nursing advisory committee can assist these administrations in maintaining proper professional standards and in enlisting the coöperation of the constituent, professional membership in such programs. Local nursing programs submitted to the state relief administration for approval should be submitted to the nursing advisory committee for comment, before final approval is given. The nursing advisory committees should be consulted by relief administrations with regard to disputed problems of nursing policy and practice.
This means that requests for such committees are mandatory although the adoption of the recommendations of the committees rests with the relief administrations. It is, therefore, important to see to it that local and state relief administrations ask for the appointment of such committees, remembering that this neither commits them to paying for nursing care nor necessarily for accepting the recommendations of the committee although the latter would be the desired result. See N.O.P.H.N. suggestions for plan, page 637.

b. Suggestions as to make-up of nursing committees.
As already noted through conferences of the N.O.P.H.N. with Mr. Hopkins and members of his staff and as implied in Rules No. 7, it is clear that it is the intention of the F.E.R.A. that nursing service in the home to unemployed families on public home relief shall be given chiefly on a visit basis through the existing agencies, usually visiting nurse associations, already organized and giving such service to the community. It is obvious that such use of already operating community services is both the most economical and efficient method of insuring such service for the unemployed.
Therefore, it would seem essential that these state and local nursing committees be largely made up of those most closely in touch with the services that will be needed and paid for—

1. Suggestions for state committee:
   Representation from the public health nursing personnel of the state department of health;
   The president of the S.O.P.H.N. where one exists, or the chairman of the Public Health Nursing Section of the State Nurses' Association or individuals chosen by them;
   One or two other outstanding public health nurses in agencies giving bedside care in the state;
   The chairman of the Lay Section of the S.O.P.H.N. or president of a public health nursing lay organization where these exist or an outstanding board member of a public health nursing agency;
   The president of the State Nurses' Association or representative appointed by her, and a representative from an "official" nursing registry administered by or under the direction of a district association of the State Nurses' Association.

2. Suggestions as to local nursing committees.
   Representation from the staff and board of the public health nursing agency organized to give bedside nursing care.
   One other outstanding public health nurse from the area covered by the relief administration;
   Representation from the official nursing registry if there is one, and from the District Association of the State Nurses' Association.

IV. *Suggestions to agencies applying to relief administrations for authorization for bedside nursing care in the homes of the unemployed on home relief to be paid for from relief funds.*

a. It is clear that there will be some reluctance on the part of some relief administrations to accept this additional financial burden. Therefore, it may be necessary to give evidence in service figures and dollars and cents as to the extent of the burden on the local agency and how the general economic situation and the caring for unemployed families have affected both the income and expense budget during the past several years and the resulting curtailment of program for the rest of the community for the sake of the unemployed.

b. The following *comparative figures covering several years,* if they could be produced would be the strongest argument.
   1. Percentage and figures by years of free visits.
   2. Percentage and figures of free visits that were made in the families of the unemployed on public home relief.
   3. Percentage and figures of paid and part-paid visits.
   4. Percentage and figures of earnings—all sources.

5. Percentage and figures indicating any other income showing increases and decreases.
6. Give figures showing comparative changes in expenditures for the same period of time in regard to the following:
   a. Size of staff
   b. Salaries
   c. Curtailment of program
      Under this heading, if the complete program has been curtailed such as general reduction in instructive visits or if any section of the program has been cut out in order to carry the extra load of free visits resulting from unemployment and because of reduced income, give the figures that will show this.
7. Excess hours of work, increase in number of visits beyond efficiency and drastic salary cuts might also be pointed out.
8. Where capital funds have had to be used or a deficit incurred—or both—this should also be stated.

Because many agencies already are giving the necessary bedside nursing care to the unemployed any factual material that can show at what a sacrifice this has been to other essential services needed by the community and also at what jeopardy to the agency's own financial resources, will add weight. Certainly if the agency can supply these services on available income without serious losses, there is no reason why the money should be supplied out of the all too inadequate public funds.

c. Strong public opinion may be needed to back these requests which may mean public opinion sufficient to increase the total amount of available relief funds. The lines of approach should be remembered—in the following order: local, state, and federal.

d. Payment from relief funds for bedside nursing care on a visit basis will for the most part not be a heavy drain on relief budgets nor will it solve the financial problems of local agencies. Judging from a few agencies that have analyzed their free visits over a period of months, it has been found that only 10 percent were in homes of the unemployed on public home relief and were of the type that would be paid for according to Rules No. 7. Such facts may be a talking point with relief administrators who are fearful of a large increase in their own expenditures; and with community chests which fear that the payment of public funds to private agencies may invalidate their plea for support.

V. *Possible use of the N.O.P.H.N.*

a. We are glad to advise as to any local plans.

b. If problems arise either in regard to policy or administration that cannot be met locally or through the state relief administration, these could be referred to the N.O.P.H.N. for consultation with the F.E.R.A.

c. In any case, we would be glad to have copies of all plans filed in the N.O.P.H.N. office as these would be of direct assistance to other localities.

VI. *Suggestions as to a plan for rendering bedside nursing care as provided in "Rules and Regulations No. 7"—to be submitted to state and local relief administrations.*

The following are some of the essentials that the printed statement from the F.E.R.A. seems to indicate must be considered in developing a plan for nursing service on a visit basis:

a. Policy

1. Provision for bedside nursing service on a visit basis in cases of illness and maternity cases in the homes of the unemployed will be through the local nursing agency which is already offering bedside service on a visit basis to maternity cases and those ill in their own homes as part of their established program. In the large majority of places, this service is administered by a "private" visiting nurse association. In a small number of places it is administered jointly by a combination of a visiting nurse association and the Department of Health. And in a very few cities the Department of Health itself is the only community-wide agency including bedside care in the home.

2. Where there is no agency in the community which includes a bedside nursing service on a visit basis in its regular program, agencies that employ public health nurses, such as departments of health and boards of education, might be requested to develop a bedside nursing service for unemployed families. Where it is necessary to develop this as a new service, it would be important to have guidance from some recognized public health nursing organization and essential to provide qualified public

health nursing supervision. Also nurses with public health nursing experience should be employed.

3. Where nursing care is needed on more than a visit basis, the agency supplying the service on a visit basis would cooperate with the "official" registry (or the best professional source where no "official" registry exists) in supplying nursing personnel.
4. The policy adopted shall be to augment and render more adequate facilities already existing in the community for the provision of bedside nursing care. It shall imply continuance in the use of nursing services already established in the community and paid for, in whole or in part, from local and/or State funds in accordance with local statutes or charter provisions. Federal Emergency Relief Funds shall not be used in lieu of local and/or State funds to pay for these established services.

b. Procedure

1. Written order
   Authorizations for bedside nursing care should be obtained in writing from the local relief officer prior to giving such care except where authorization has been obtained by telephone and immediately followed by a written order. When a physician is in attendance on a case, authorization for bedside nursing service will be given on his recommendation and the care given under his medical orders.
2. Acute illness
   Authorizations for bedside nursing care for acute illness shall be limited to a definite period and a minimum expenditure or number of visits according to the nursing plan accepted. For example, it may be agreed to allow not more than two weeks or ten visits. Any extension of visits or time beyond the limit decided upon shall not be authorized until after a re-investigation of the case in the home by the local emergency relief administration.
3. Chronic illness
   Bedside nursing care for chronic illnesses shall be authorized in accordance with the need for such care as indicated by the attending physician. In general, the frequency is not to exceed more than one visit per week for a period not exceeding two or three months. However, if necessary, more frequent visits for an acute attack occurring in the course of a chronic illness may be authorized. Care for chronic illness authorized under this section shall supplement and not supersede existing community services.
4. Obstetrical care
   Authorization for obstetrical service in the home shall include an agreed number of prenatal visits, delivery service in the home where desirable and necessary postnatal care.

Note: The above procedure in relation to bedside nursing care where authorized shall be provided under an agreement made with relief administrations and nursing organizations. Where there is no community agency already organized to give bedside care on a visit basis, nationally accepted standards shall be adopted by any organization inaugurating a service on a visit basis.

5. Fee schedule
   Where bedside care is authorized, the flat rate per visit shall be established by agreement at not to exceed the certified cost per visit based on the nationally approved method of cost analysis. In most visiting nurse associations this will be the fee paid on contract with insurance companies. Where the agency has no such contract and has not worked out an approved cost analysis, the basis for agreement would probably be the customary local charge per visit.
6. Bills
   An itemized bill for each patient shall be submitted to the local relief official monthly (within ten days after the last day of the calendar month in which such medical care was provided). Each bill shall be chronologically arranged and contain at least the following information: name, age, and address of patient; general nature of illness or diagnosis; whether home or office treatment; dates of service; and status of case at end of month—cured, sent to hospital, dead, needs further care, etc.
   Bills for nursing care shall be accompanied by the original written order for such care, except for cases in which nursing service under an authorization has not terminated during the calendar month covered by the bill, in which cases the bill shall show, in addition to the details required above, the date and serial number of the outstanding order. Retroactive authorizations shall not be issued or honored for payment.

WINNERS IN RADIO SKETCH CONTEST

First Prize—*Inspiration* by Mary Reeves (Mrs. Addison) Young, R.N., Houston, Texas.

Second Prize—*Mrs. Barclay Learns About Diphtheria Prevention* by Marie Dandridge, R.N., Baltimore, Md.

Third Prize—*A Quiet Hour in the Health Office* by Mrs. Virginia Chambers, Bel Air, Md.

The winning sketch appears here.

The judges were:

W. W. Bauer, M.D., Director, Bureau of Health and Public Instruction, American Medical Association, Chicago, Illinois.
Mrs. George Kuchler, LaGrangeville, New York.
Agnes G. Talcott, R.N., Director of Nurses, Department of Health, Los Angeles, California.

There were thirty-one entries in this contest. The judges' decision was unanimous in the case of the first prize sketch. We are hoping that *Inspiration* will be put on the air by a local station, since it is peculiarly adapted to a New York City audience. The other two sketches will be published at a later date. They are typical of almost any community and this magazine will be glad to release them after publication for use by any public health nursing agency, provided mention is made of the N.O.P.H.N. and this magazine.

To all those who competed in the contest the editors wish to say thank you! As usual, the entries that did not win prizes had many fine points. We are more convinced than ever that the radio can carry our message and paint a picture for the unseen and unseeing audience almost as well as the printed page. Writing for the radio is an ability well worth cultivating.

The details of our *1934 Contest* were published in the November number of this magazine, page 592, and may be secured on request.

Inspiration

A Dramatic Sketch

By MARY REEVES YOUNG, R.N.

CHARACTERS IN SKETCH:
LILLIAN D. WALD
MARY BREWSTER
A CHILD—Evelyn
A WOMAN in class
MOTHER of child, Mrs. Smith.

PRELUDE

(To be spoken by narrator)

When in 1912 the National Organization for Public Health Nursing was organized, no other person was thought better fitted to be its first president than Lillian D. Wald, founder of Henry Street Settlement. The story of her life on Henry Street, in East Side New York, is a long one, and filled to the brim with dramatic events. We have taken the first one mentioned in her book, "The House on Henry Street," for this sketch.

SCENE I

Narrator: The year is 1893. The place is a school room on the East Side, New York. Miss Wald, a recent graduate of a nurses' training school has been asked by a philanthropic society to teach home nursing to a group of mothers on the lower East Side. Filled with a tremendous zeal for work and a deep sympathy for the poor, Miss Wald eagerly takes this opportunity to attain her life time ambition—to nurse the poor.

SCENE I
(*Continued*)

Miss Wald: Now I will show you how we make the bed. See—we tuck the sheet well over the head of the mattress, square the corners, tuck smoothly on this side . . . (Pause) Now we pull the sheet tight on this side so there won't be any wrinkles under the patient's back, and tuck it firmly under the edge of the mattress. (She speaks slowly suiting her words to her action.)

A Woman: 'Scuse me, Miss Wald, they's a little girl here wants something.

Miss W.: What is it child?

Child: My mummy's sick. Can you make her well?

Miss W.: I might be able to do something for her.

Child: She's awful sick. She's in bed and can't get up. And there's a little new baby, too.

Miss W.: Where do you live?

Child: On Ludlow Street.

Miss W.: I'll go home with you. Wait just a minute till I have finished this bed. You may watch me, and learn how to do it too.

Narrator: Led by the little girl, Miss Wald walks in a cold March rain through the most squalid section of the East Side to a back tenement on Ludlow Street. They climb narrow stairs to a tiny upper apartment.

SCENE II.

Child: This is where mummy is. (Opens and closes door) Mummy, here's the nurse lady.

Mother: Evelyn, you hadn't ought to brought nobody in the room when it looks so messed up. (To Miss Wald) But thank you, Miss, for coming.

Miss W.: Good morning Mrs. Smith. I'm a trained nurse. Won't you let me make you and the baby more comfortable?

Mother: That's awful kind.

Miss W.: Evelyn, can you show me where to heat some water?

Child: I know how to fix it. I'll get some coal oil out of the lamp, for the stove.

Miss W.: And here's the little new brother. My what a fine looking young man. You'll have a warm bath in a minute, young fellow! Did you have a doctor for him, Mrs. Smith?

Mother: Well, no. One of the neighbor women came in. She sorta makes a business of it.

Miss W.: Has anyone been in to help since?

Mother: No'm. The children do the best they can.

Miss W.: And your husband?

Mother: Oh, he's on the street all day. He ain't got but one leg, and he sells things.

Child: Sometimes people give him money, and don't take his pencils.

Mother: Evelyn!

Child: The water's hot now, Miss Nurse.

Miss W.: Now young fellow, it's bath time. Watch how I do it, Mrs. Smith, so you can bathe him as soon as you are strong. He must have a nice bath every day. Evelyn, you watch too, so you can help your mother.

Child: Oh, I'd love to do that.

Miss W.: First his little face is washed with this soft cloth dipped in warm water. Then his tiny nostrils have to be cleaned and finally we attend to his ears.

Mother: I didn't know you had to do that.

Miss W.: A shampoo next, then off with his clothes. Now he is gently washed from head to foot with warm water and pure soap, keeping him covered like this, so he won't take cold. Now we are ready for his back . . . (While she speaks her voice fades and dies away as the scene comes to an end.)

Narrator: That night Lillian Wald was unable to sleep. Her mind went over and over the details of that unbelievably miserable existence which had been re-

vealed to her so vividly in that day's experience. She sought for a way to remedy it. The next morning she went to her friend Mary Brewster.

SCENE III.

L. Wald: Mary, something happened to me yesterday.

Mary: This is serious. Have you met the one and only?

L. W.: I know I have, but not the way you mean. Mary, I'm going to move down in the East Side and help those poor people. Will you come with me?

Mary: Just what are you talking about?

L. W.: This is what I mean: Yesterday I saw poverty and misery and ignorance that made me ashamed of the society I live in, ashamed because we calmly go our way while all the time thousands in our midst live in such awful misery. Something must be done to make New York see what the East Side really is.

Mary: You make me feel ashamed, too! Tell me what you saw.

L. W.: I was giving my class a lesson in bed-making. A little half-starved girl dressed in rags came in. She wanted me to go to her mother—there was another baby. She led me through the most awful streets—streets that were unpaved and muddy and piled with filth. It was raining. Dirty pushcarts with fish and rotten vegetables lined the curb. Open garbage cans stood out front. The odor was frightful.

Mary: I can imagine.

L. W.: On Ludlow Street we went into an ugly tenement, and up the rear stairs that were caked with slime and filth. Before I ever reached the child's mother, I began to feel ashamed of a city that lets such things exist.

Mary: That *was* awful.

L. W.: We went into the apartment. There were two small rooms, all the home of a family of seven. And besides that they take roomers, people who sleep somewhere on the floor. Really. And that poor woman! She was stretched out on a miserable bed that hadn't been cleaned since the birth. Neither had she nor the baby. I bathed them and did what else I could. The woman was pitifully grateful. She kissed my hand. It was very embarrassing. It made the whole wretched business look even worse. Because those people are not criminals. They are not degraded in a moral sense. Society can not excuse itself on such grounds. I simply must do something about it.

Mary: Now I do understand. What are you going to do?

L. W.: I believe that if we can live in the tenement district as nurses we can really do some good. We would identify ourselves with the people there. They would accept us. That's the whole plan in a nutshell. Will you come with me?

Mary: Yes.

Narrator: And that was how a great social reformation was started in New York City, by two young nurses.

The Why of Nursing Records *

From the Viewpoint of the Staff Nurse

WHAT IS ALL THE FUSS ABOUT?

ONE cannot work long in the field with staff nurses and with the directors or supervisors of nursing services without hearing animated and frequently violent discussion of nursing records. The staff nurse argues that the records are too detailed; take too much time; that no one ever uses them, much less herself; and, anyway, she can remember all the important facts about her cases usually too well for her own peace of mind. Nursing directors and supervisors lament the failure of the staff nurse to consider the record of the case as an aid to her memory and something to be studied as any chronological series of observations; the lack of uniformity in recording; and that the most important point is always a blank when she is called on in a hurry to review the case. The extent to which these conditions actually exist or are present in the minds of a nursing staff varies considerably; however, they are ever present to some degree.

The problem is to develop a common viewpoint concerning records which will serve as a guide to all those concerned. Making such a point of view a part of the thinking of each staff member in an organization necessarily depends upon a program of staff education and an assignment of responsibility for records, their use and analysis which does not always exist.

It is a favorite expression that "records are tools for the nurse to use." It should be said that one cannot be expected to use a tool with ease, confidence and to good effect, be it a crow-bar, screw driver or microscope, unless one fully understands at least its purpose and principle. Usually there must be some definite training of the individual, some demonstration of the use of the tool and friendly sympathetic supervision of the results of a few trial or experimental uses.

In this discussion, it is hoped only to point out some of the more important uses and reasons for records as they relate to the individual nurse, whether she is working alone or as a member of a staff.

OUR MEMORIES SOMETIMES FAIL US

Nursing service, and particularly public health nursing service, has developed from giving helpful and sympathetic care to, and relieving the suffering of, persons sick in the hospital or in the home and has assumed a more forward looking attitude. With medical guidance the nursing agency is carrying out planned services for health protection or promotion, as well as for sickness care, and the need of a record to augment the memory of the individual nurse in dealing with a specific case, has become increasingly apparent. This need is the mark of a service changing from one

*The problem confronting the N.O.P.H.N. and all public health nursing in this country is how to get more effective use of records and to bring them to bear upon local problems. The sub-committee of the N.O.P.H.N. Committee on Records has been assigned this problem for study and action. The Committee, through its members and individual nurses on their staffs or immediately available to them, has given careful consideration to the problem and the probable reason for the status disclosed by the survey which may be summarized as follows:

> "Assuming that the general purpose of the records and statistics of any agency is first to assist the individual nurse in rendering a better quality of service; second, to assist the organization in helping the nurse to render a more adequate service through the material revealed in the records and statistics; and third, to give a basis for studying and measuring community needs and the program of the agency itself as it relates to these needs, the survey shows that for the public health nursing services as a whole, these purposes are not now being realized—with individual exceptions."

The Committee hopes, through a series of articles dealing with the phases in the use of records, to clear up some of the misunderstandings and misapprehensions which exist.

which is altogether opportunistic to one which plans scientifically the care to be given. The care must be based on observations thoughtfully recorded of the environmental and other factors affecting the cases. A true scientist has been accustomed and schooled to observe phenomena in his field and may be trusted to start out with a blank sheet of paper and record all of the significant factors in any way relating to the subject of his observations. If his experiments or work extend over a long period, he will certainly automatically develop a standard procedure in observing and recording significant facts. He does not rely upon his memory from day to day but, by carefully chosen, and so far as possible exact, terms, by measurement and by drawing, describes the conditions under which the work was carried on, what was done, and the result.

Field services in nursing did not grow out of such definite laboratory experience and it is not surprising that many nurses who have found their way into public health work have relied upon their memory and upon a few sketchy notes hurriedly made to carry the history of individual cases from day to day. We have also had public and private officials directly and indirectly responsible for nursing service who think records primarily an excuse for the nurse to spend an hour or two in the office. On the other hand, those interested in the promotion and further development of greater effectiveness in public health nursing work have encouraged the development of detailed records which serve as a guide to the nurse in the conduct of an individual case. If the nurse thoughtfully records the conditions, services, problems, accomplishments and failures at the time of, or immediately after, each nursing visit, she must perforce think discriminatingly concerning the case, the service which she has provided it, and the results which accrue. Between these points of view there is a wide divergence and we hear pleas from public and private officials and frequently from the staff nurse for the utmost simplicity in records; for a large sheet of paper and plenty of space to write. There is frequently lack of concern about what, at the moment, seem inconsequential details.

There is, of course, the middle ground which is sound administratively, is economical of time, is sufficiently scientific so that the recorded material will have value when studied for groups. This middle ground is the sound point of view for a national organization to hold and is, fortunately, the point of view held by those staff nurses who are equipped by training and experience to use records to the best advantage to themselves and to the program. Every nurse, whether she be a member of a large staff or an individual working alone, will have two primary concerns: first, to give the most effective care which she can to the patient, and second, to develop the work both as to content and extent of program, and to develop public understanding and financial support. We must consider records from the standpoint of the staff nurse in these two main categories.

AS AN AID IN CARE OF CASE

The case record provides a convenient place for identifying information and all significant items in the history of relationships of this case to the community. Without considering the form in which these items should be recorded, we may discuss a maternity case and consider some of the entries that would be likely to be made on such a form, the reason for so doing, and indicate in what ways the entries serve.

HISTORY

Under this general heading one notes age, color, marital status, apparent economic status, occupation, disease history of patient and patient's husband with particular reference to venereal disease, tuberculosis, or mental conditions. It is also of interest at the time of taking on the case to know what physician or midwife has been in touch with the case and the history of previous preg-

nancies, particularly if there were complications. In getting the history of previous pregnancies, there should be recorded their months of prenatal care received, whether delivery was in the hospital or home, by doctor or midwife, at term or premature, whether the pregnancy resulted in a live or stillborn baby and whether delivery was operative or normal. Only from such facts can one determine the mother's probable requirements and with the information do a discriminating job in the handling of the case. The problem of supervision and the intensity of service will be different in the case complicated with syphilis or tuberculosis in patient or husband, or where there is a history of repeated miscarriage or abnormal delivery, from the case which gives a history of no complications in several pregnancies.

Discrimination exercised by the nurse in the kind of care to be given cases should be backed up by the medical judgment of the physician caring for the case, whether private physician or in the clinic. Since, however, the nurse is frequently the first person to contact the case and to get the history which indicates the probable presence of complications, she must, for her own protection, record these significant items completely, and with some thought of their interrelation and the way in which they should influence the care which is to be given.

PLAN OF CARE

Two patients rarely present the same problems and the service cannot be routinized. To make it individual, one ought to have the significant facts in the history of the individual. The plan of care does not need to be formally recorded and should not be fixed so that it cannot be molded to fit changing conditions in the patient. For this reason, there are certain important items relating to the conditions of the patient which need to be frequently observed if the nurse is to detect early signs of abnormality and to guide the patient in hygienic ways of living. Such items are included in the record of antepartum visits on the maternity record of the N.O.P.H.N., Form 68. Though one may differ with this selection in details, they are in general items which a nurse does have in mind and observe at the time of visit. Recording her observations at the time will help recall conditions later.

- Date
- Temperature
- Pulse
- Respiration
- Blood pressure
- Teeth
- Nipples
- Varicose veins
- Edema
- Foetal heart
- Persistent headaches
- Nausea or vomiting
- Vaginal discharge
- Constipation
- Disturbed vision
- Sleep and rest
- Fresh air
- Bath
- Clothing
- Vegetables and fruit
- Eggs and meat
- Milk
- Water
- Mental attitude
- Urinalysis
  - Sp. gravity
  - Albumen
  - Sugar
- Med. exam.
  - Private physician
  - Clinic
- Dental service
- Reported to physician

It should not be inferred that the order in which the items are presented is essential, that these are the only items which need be observed or that all the items will be equally important every visit, particularly if the visits are either very frequent or very infrequent. It is believed that there are certain observations having to do with the condition and manner of living of the patient which the nurse ought to observe periodically if what we now consider satisfactory prenatal care is to be given.

TO CODE OR NOT TO CODE

The condition of the patient in various aspects classified in accordance with this or a similar code, makes it easy for the nurse to record the findings in terms which are reasonably intelligent to any person picking up the record. The diffi-

cult thing is the mental process which precedes the making of the record. One hears the criticism that recording by code in a small space cramps the style and that it would be better to design the records in such a way that a nurse could describe the condition of the patient in detail. Unfortunately, the powers of description vary from individual to individual to very great degrees and it is with difficulty that we compress our thoughts into a few well chosen and exact words. The use of a record which may be checked or recorded in code is intended to provide the nurse, or any other person to whom the nurse may wish to interpret the condition, a fair picture of the circumstances on the date of a particular visit. As such, it furnishes a partial record of her visit to be supplemented from time to time by written remarks of a more general nature or having to do with the specific problems or conditions that have arisen or plans for the care of the case. From these recorded observations and the analysis of them, the nurse will automatically adjust her planning and her program of service to fit the need. Only by constant contacting of conditions, review of what has been done, and what results have been attained, and a restating of the problem of the case from time to time, can intelligent, thoughtful and individualized service be rendered. Though the record itself may deal very largely with the patient, the nurse will see the patient in relation to environment and their inter-action for good or evil. One must ever be conscious, particularly in making progress reports, that change may be either positive or negative and that frequently what we regard as failure or negative progress may be of as much help in evaluating any service as the more favorable results.

THE RECORD SHOULD TELL WHAT YOU DO

In observing these conditions, the nurse, relying upon her training and experience, must decide in one of three ways:

(1) That the patient in this particular regard is in satisfactory condition

(2) That the condition is to some extent unsatisfactory and needs careful watching

(3) That the patient is in serious condition, and needs medical attention at once.

It is obvious that certain items have greater significance if observed frequently than at long intervals and that it is from the general trend of conditions rather than from a single observation that decisions are more intelligently made. However, even though the contact may be infrequent, a well recorded visit which includes a careful resumé of the condition of the patient serves as a protection to the nurse in studying her record of service to the case.

Not infrequently are health departments and public health nursing agencies accused of being negligent because they have knowingly permitted serious conditions to persist without adequate attention. If one has a record which shows the condition of the case and that the patient was urged to secure aid because of a serious condition or that such conditions were called to the attention of the supervisor or other responsible person, then not only is one's reputation saved but the agency is protected and the integrity of the service established.

What has been said about the details to be recorded concerning antepartum care applies also to records of delivery and postpartum visits where these services are provided. Even though routine postpartum care may not be given by an agency, an instructive visit during this period will be far more effective if based upon observations of the condition and hygiene of the patient and of the newborn baby as indicated by the items included in this record as follows:

Postpartum

Date
Temperature
Pulse
Respiration
In bed
Fundus
Urine
  Catheterized
  Voided
Sutures
Breasts
Nipples
Lochia

Constipation
Sleep and rest
Fresh air
Appetite
Vegetables and fruit
Eggs and meat
Milk
Water
Mental attitude
Reported to physician
Remarks and services rendered.

Newborn

Sex
Condition at birth
Malformations
Prophylactic in eyes
Date
Weight
Temperature
Cord umbilicus
Skin and scalp
Eyes
Ears
Nose and throat
Sleep
Fresh air
Regular stools
Urine
Bath
Feeding
  Breast
  Formula
  Amount
  Interval
Water
Vomits
Remarks and service rendered.

If the service rendered involves routine bedside care and visits are made daily, all of the items may not necessarily be recorded every day. They all must be observed at some time during the postpartum period if adequate supervision is being given. All abnormalities in this period may well be the subject of special comment.

SITUATIONS NEEDING HELP

In reviewing and summing up the condition of the patient in this manner, the individual nurse will frequently find situations which need care and help beyond her own capacity. These, through referral within the agency or without, should receive attention and the record indicate for what condition and in what ways the patient was assisted. The planning of the service to the case will automatically bring to the attention of the nurse those conditions with which she cannot cope, the recording of these conditions, the services ultimately rendered and by whom, and will indicate to those interested the thoughtful way in which the nurse has handled her problems.

All of the items so far discussed in the care of the case have to do with the individual case and caring for it in the immediate present. There are other services which the record performs and ways in which it aids the staff nurse in her daily job. She cannot help but question at times the results of her care of different types of cases. Case records furnish a basis for the analysis of groups of cases on this basis. A simple tabulation of such items as the month of pregnancy in which cases are coming to nursing attention, the average period for which cases are carried, the percentage of cases carried for so short a time as to fail to secure the greatest benefits from nursing service, cases returning for nursing service in succeeding pregnancies, cases referred by private physicians, midwives, neighbors, etc., will reveal the status of one's work in an interesting and stimulating way. Unfortunately, too few nurses have the opportunity to make such an analysis of their district and services and fail entirely to see this use of well kept records. From such a study of the trend of services from year to year many items which will help in interpreting the service to the public may be derived.

CASE RECORDS AS AN AID IN DEVELOPMENT OF PROGRAM

The analysis of groups of cases as just discussed will provide the information regarding who is served, what amount of service is given both in gross and in the average case, the results obtained in live babies and sound and healthy mothers which are the ultimate objectives of the nursing service in this field. From the way in which individual problems are handled and the record is made of the same, there may be drawn many stories of great human interest which frequently go further in developing public appreciation and understanding of the service than do carefully prepared statistics of what has been accomplished

in the reduction of mortality and morbidity.

Records showing the groups served, the services rendered, in terms of nursing visits or special care given, form the basis for estimating the cost of the work in a particular field. We are coming more and more to consider, in these days of shrunken budgets for public health work, the results obtained in relation to the service rendered. Well kept case records which may be studied from year to year and the analysis of which may be presented to the public will go far in establishing the worth whileness of the service.

Although it is frequently necessary to utilize special records for special studies, the distribution of the intensity of the service in relation to specific problems can be satisfactorily determined from the usual well kept case records. It is a mark of distinction that in the reduction of health budgets which has occurred throughout the country in the last three years, nursing services have been affected to such a slight degree. If this public confidence is to continue, we must be prepared to show beyond question that services rendered in individual cases and to groups are as effective in health promotion and the control of mortality and morbidity as we believe them to be.

(This article is available in reprint form.)

MORE CHRISTMAS CARDS

As in previous years, we are glad to call attention to the Christmas cards sold by the International Grenfell Association, the proceeds of which are used to help carry on the work for children in northern Newfoundland and Labrador. This year there are three cards—a child on a doorstep in a Grenfell dickie, Sir Wilfred's personal sketch, (colored in brown, blue, and red, price 15 cents) with this verse by Joyce Kilmer:

Unlock the door this evening
And let your gate swing wide.
Let all who ask for shelter
Come speedily inside.

What if your yard be narrow
What if your house be small?
There is a Guest whose coming
Will glorify it all.

"A Labrador Dog Team" (blue and white with a touch of red) with the message: "Just to wish you an Old Fashioned Christmas" (Price 10 cents) and a red, black and white folding card "A Merry Greeting from all of us on Christmas" (Price 5 cents). Envelopes included. These cards may be secured from The International Grenfell Association, 156 Fifth Avenue, New York, N. Y

PLEASE BE PROMPT

We find that our subscribers are so appreciative of our continuing their subscriptions for a month after they expire by sending the 13th copy, that we plan to continue to do so. This means, however, that in order to get the *14th* copy, a renewal must reach us before the 20th of the month preceding the 14th issue.

In other words, if your subscription expires with this issue (December) and your renewal does not reach our office before January 20, you will not receive a copy of the February issue.

Classes for Prospective Fathers

By ELDRED V. THIEHOFF, M.D.

ON September 6, 1933, the Cleveland Child Health Association started something new for Cleveland in prenatal instruction. This was a class for prospective fathers.

Since 1922 prenatal classes for expectant mothers have been conducted by Mrs. Ellen D. Nicely, R.N., Instructor in Prenatal Education. Her classes, which have been held in connection with prenatal clinics in the various hospitals, have been a vital factor in promoting prenatal welfare in the city.

Many of the women attending Mrs. Nicely's classes have had a multitude of questions to ask as coming from their husbands. Thus, it was realized that men not only needed advice and information, but were seeking it. Certain it is, that men need to be instructed not only as regards their duty during the prenatal period, but also in the art of being a successful parent. After all, due to present economic conditions many women are now the bread earners of the families, while the husbands remain at home looking after the children. In such cases it is important that they should know how to care for children properly.

The class for fathers was started on an experimental basis at the University Public Health Nursing District, 2573 East 55th Street, with the thought that if this proved successful the plan would be expanded to include other parts of the city.

The first question was how to contact expectant fathers to enroll them in the class. Announcements of the class were printed with a coupon attached for the men to sign, signifying their intention to attend the lectures. Mrs. Nicely passed these out to the women in her classes, asking them to urge their husbands to attend. These announcements were given also to nurses of the University Public Health Nursing District and the Visiting Nurse Association for distribution as they made home calls and came in contact with prenatal cases. Considerable newspaper publicity also was obtained. The announcements read:

"To Fathers and Prospective Fathers:

Are you to have a new baby in your home? If so there probably are many questions you would like to ask such as:—

What is a child born with?

Can the child be marked before birth?

How may I help in preparing for the new baby?

How soon shall we engage the services of a doctor?

What is considered good care of the baby?

Should we travel with the baby?

What are the common illnesses to be expected in childhood?

How soon should we start to make the child obey?

To help you answer these and many similar questions, the Cleveland Child Health Association has arranged to offer free a series of talks for fathers. These will be given by three physicians. After the talks the doctors will confer with you personally about individual problems.

The fathers will meet for these talks each Wednesday evening from seven to eight, beginning September 6, 1933.

If you wish to attend these talks, please sign the coupon below and return to, etc."

The coupon read:

"I am interested and wisn to attend the free talks for fathers and prospective fathers to be conducted under the auspices of the Cleveland Child Health Association at the University Nursing District, etc.

Name .....

Address ....."

The first session was held on September 6, 1933. The group meets each Wednesday evening from 7:00 to 8:00 p.m. The class is free to all men who wish to attend. The first half-hour of each session is devoted to lecturing and the last half-hour to individual conferences.

There will be fifteen sessions, the first three covering the prenatal period and the father's responsibility; the next six relating to the delivery of the infant and

its care up to the second year; the next three being devoted to the preschool child, the school child, and the diseases and disorders of childhood; the last three taking up discipline and child behavior problems.

Thirty-five men have enrolled in the class, which has been quite successful. The men are very interested and have many questions to ask. It is hoped that the classes may be extended rapidly to other parts of the city and that in the future Cleveland will be assured of intelligent and informed fathers.

MATERNITY CARE VOLUNTEERED

This is a plan by which neighborhood doctors have volunteered to give maternity care for reduced rates to maternity patients of the Minneapolis Visiting Nurse Association.

In Minneapolis the only set up for free medical service in home deliveries is in connection with the University Hospital Out-Patient Department. This year many of our patients have had difficulty in making plans with this department for home deliveries. We therefore consulted our Medical Advisory Committee last spring, and its chairman in turn took up the problem with the Welfare Committee of the Hennepin County Medical Society. Later an announcement appeared in the Medical Society Bulletin stating that the Visiting Nurse Association would like the names of any doctors who would be willing to attend maternity patients in their homes at the time of delivery for what the family was able to pay, even though it was no more than five or ten dollars.

As a result, twenty-three doctors have volunteered their services. They themselves have stipulated that if the family has in the past used some doctor as a family physician, the patient shall first make contact with this family physician, explaining her situation and asking him if he wishes to take care of her at the rate she can pay. In almost every case where there was a family physician, he has agreed to care for the maternity patient himself. For this reason we have really used the volunteer physicians rather seldom. Where there has been no family doctor we have given the patient the names of doctors in her neighborhood who have volunteered for service, and she has selected one of them. After the patient has decided on her doctor, the visiting nurse calls him to make an appointment, and to explain the patient's financial situation. In each instance the service has been most satisfactory.

We have visited each doctor who has volunteered so that he may have complete understanding of the plan.

Care includes at least two prenatal visits by the patient to the doctor (more if necessary), and also includes a sixth week postpartum examination. Our delivery nurse assists the doctor at the time of the delivery. The doctor examines the patient when referred, making a general prenatal examination, and also taking pelvic measurements. Late in pregnancy he sees her once more in order to check on her general condition, and to determine position of the foetus.

The doctors are willing to offer this service for two reasons: in the first place they feel a responsibility for the welfare of sick people in their neighborhood, and always have done considerable work without charge; in the second place, they feel that many of these patients in families where there is unemployment now, are potentially able to pay at some later time, and they feel it worth while to make and keep contacts of this kind.

RUTH HOULTON,
Director, Visiting Nurse Association, Minneapolis, Minn.

Maternal Health

Throughout the year much good material appears relating to maternal health which is not very accessible to our readers. This year we are printing excerpts from a wide variety of articles—partly to give helpful information in a nutshell, partly to indicate where more detailed facts can be found in current periodicals.

PRENATAL PERIOD

Dr. John Whitridge Williams said:

"My advice to the modern young woman seeking full advantage of modern obstetric knowledge is not to participate in more than a moderate amount of swimming, hiking, horseback riding, tennis, and other such activities that require vigorous body movements because they toughen the muscles and the extremes of these activities are actually harmful. Nature did not intend the expectant mother to be muscle-bound . . . "

Bird, A. R., *Progress of obstetric knowledge in America*. Hygeia, May 1933.

In Russia the expectant mother is given a certificate of pregnancy by her physician or clinic. This allows her special privileges on trains, in coöperative stores, etc. She does not have to stand in line or wait in crowds unnecessarily.

Two months before and two months after the birth of a child she receives a complete holiday on full wages. In Moscow in 1931 there were 35 consultation centers and 30 maternity hospitals. (Population about 2,000,000.) Certified milk is supplied by the government to babies not breast fed.

Jewesbury, E. C. O., *Maternity and child welfare work in Soviet Russia*. Maternity and Child Welfare (London), November, 1932.

"A rather intensive maternal hygiene program has been conducted in Williamson County, Tennessee, (Population 22,845) during the past six years without materially interfering with the other required and necessary health department activities.

The number of supervised cases has steadily increased from year to year. A total of 74.1 per cent of all births reported in the area for the fiscal year ending June 30, 1932, and 38.3 per cent of all reported births in the six-year period had both prenatal and postnatal nursing care.

The average time of admitting prenatal cases for the past two years was about the seventh month of pregnancy as compared to late in the eighth month for the preceding two years.

The number of deliveries by midwives has apparently declined during the period.

The maternal mortality rate from all causes for the period 1927-1932 was 0.9 per 1000 in the supervised group and 5.9 in the unsupervised. From causes classed as preventable, no deaths occurred in the supervised group, while the unsupervised suffered a rate of 4.1 per 1,000.

The supervision of 50 per cent of prenatal cases in Williamson County has been associated with what we believe to be a significant decline in the maternal mortality rate."

Williams, W. C., M.D., and Bishop, E. L., M.D., *An outline of the maternal hygiene program and the results of six years' work in Williamson County, Tennessee*. Southern Medical Journal, September, 1933.

"I believe that physicians can greatly profit by the experience of the Victorian Order of Nurses (in Canada). The Order provides a nursing maternity service.

The cases are unselected, but the majority come from the lower economic groups where higher death rates are to be expected. Only cases which are under medical care are accepted by the Order. The nurses are graduate nurses—a point worthy of note—and if there are social needs in the home, the visiting nurse will secure the aid required through any or all of the social resources of the community. During the course of the year, the nurses of the Order attend at 6 per cent of all the births occurring in the Dominion of Canada. The maternal mortality rate for the group attended by the Victorian Order nurses is but one-third of what it is for Canada as a whole. If the same rate had prevailed for all cases, it would have meant the saving of the lives of more than 800 mothers in 1931. Do we not learn from the experience of the Victorian Order of Nurses what reasonably adequate medical and nursing care mean? . . .

"Prenatal clinics are not comparable with health clinics, nor should they, in my opinion, be organized on that basis. Well-baby clinics are, as the name implies, for well babies. Their purpose is to keep the baby well. The prenatal clinic is for expectant mothers who will go on to confinement and into a postnatal period requiring active medical care. The prenatal clinic without a confinement service is like a surgical ward without an operating room.

"In providing prenatal care, much of the supervision and most of the instruction can be given as well, and often better, by a nurse under the direction of a physician, rather than by the physician alone. At confinement, nursing service is essential. Further, the nurse will likely be more familiar with the social resources of the community, and so it is she who is the logical one to call upon such resources when there is need to do so."

Fleming, Grant, M.D., *The future of maternal welfare*. Canadian Medical Association Journal, August, 1933.

Report on work of one prenatal center, Newark, N. J., 1926-1933:

14,917 expectant mothers received care.
22,101 visits to clinic.

Maternal death rate has declined: In 1925, 88 mothers died in childbirth (10,852 births in Newark), 1931 only 34 (9,506 births.) In these five years the Prenatal Welfare Center had 59 maternal deaths in the 14,917 cases (indigent class, and a large percentage colored). Only 31 strictly obstetric deaths.

Prenatal work in Newark, N. J. American Journal of Obstetrics and Gynecology, July 1933.

DELIVERY

"The equipment of a good hospital is infinitely better than that of the best private house [for delivery]; a position on the hospital staff should be a guaranty of adequate skill, and women have discovered the greater economy of the hospital delivery. Moreover, the repair of injuries of the genital tract and the correction of displacements of the uterus, in the postnatal care, which should continue for a year, eliminates more than 60 per cent of the diseases of women. The regulation of the hospital is practicable. The control of private house practice is not so feasible. The way to improvement therefore is the rigorous inspection of all hospitals receiving maternity cases; only those being licensed in which equipment, construction, character of the staff and its organization, aseptic technic, morbidity and mortality, incidence of operative deliveries and their results, prenatal and postnatal care, fetal mortality and infantile mortality reach the level of the best modern requirements. If there is a courtesy staff, its members should be allowed to attend only normal, spontaneous deliveries or at the most use low forceps, and should be compelled to adhere strictly to a well established technic.

"In the deaths in private homes, the chief fault is the lack of prenatal care. More than half the fatal cases of toxemia had inadequate antepartum attention or none at all.

"The survey in Philadelphia coinciding in the main with others, carried out carefully by practical physicians with large experience, making every allowance for the physician in charge of a fatal case, showed that half the deaths were preventable."

"Maternal Mortality in Childbirth," Barton Cooke Hirst, M.D. *Journal of the American Medical Association*, September 16, 1933.

"It is a strange thing that many intelligent people, both within and outside the medical profession, seize upon the notion that the United States has the highest maternal death rate in the world and shout from the housetops their implicit faith and belief in that statement. The gross statistical tables indicate that the statement is true. An analysis of all the factors involved in computing the statistics shows that it is not true. It is one thing to run through a column of numerals set opposite a list of various causes of death. It is quite another to examine one by one the certificates of death and to bring into the picture the various factors and circumstances involved in each death. The two methods frequently lead to surprisingly different conclusions."

Hall, Andy. *Maternal mortality and common sense.* Illinois Medical Journal, December 1932.

Following a study of every puerperal death in Cleveland during 1931, Dr. Bolt comes to some of the following conclusions:

"The midwife, aside from abortions, plays a relatively minor rôle in contributing to the high maternal mortality rates" (in this city).

"Sepsis, toxemias and hemorrhage play the major tragic rôles and these are associated largely with hurried, operative or bizarre obstetrics."

"Prenatal care and hospitalization are accessories to the actual obstetric situation. They may or may not be associated with a low maternal mortality, depending upon the type of medical, nursing and hospital care afforded."

"Not every maternal death is at present preventable. Fundamental changes must take place in the socio-economic order and more complete medical knowledge and skill be available in order to approach this ideal."

Bolt, R. A., M.D., Dr. P. H., *Maternal mortality study for Cleveland, Ohio.* American Journal of Public Health and the Nation's Health, February 1933.

During an investigation into the causes of puerperal morbidity, the following points were noted:

A solution of biniodide of mercury was substituted for lysol in making local preparation for delivery, "as the inefficacy of lysol as an antiseptic was recognized." Nurses and doctors all wore sterilized masks. Glass catheters were used "as the interior of rubber ones was found to be difficult to sterilize."

A series of 1620 labors were conducted under other equally careful precautions and no death occurred in either home or hospital.

Ivens-Knowles, Frances, C.B.E., M.S. Lond., Ch.M., F. C.O. 9.—*Prevention of Puerperal Morbidity.* Maternity and Child Welfare (London) December 1932.

POSTPARTUM PERIOD

The leading cause of death of infants in New York City in 1932 was premature birth (1,617 deaths). "Any saving of life in this group is clearly a matter of obstetrics. Of 6,245 deaths, 81 were due to syphilis which should all have been prevented."

What kills our babies? New York City Department of Health. Weekly Bulletin, November 26, 1932.

Chief causes of diarrhea in infants: "impure milk, contaminated foods, overheating, fever from any cause, too much sugar or cream, underfeeding, overfeeding."

Marriott, W. McK. *Diarrhea of infants.* Hygeia, June 1933.

The antirachitic potency of human breast milk can be augmented in a simple and acceptable manner by including vitamin D milk in the diet of the mother during lactation.

Bunker, J. W. M., Ph.D., Harris, R. S., and Eustis, R. S., M.D., *The antirachitic potency of the milk of human mothers fed previously on "vitamin D milk" of the cow.* New England Journal of Medicine, February 9, 1933.

Conclusions from a study of loss of weight in the new-born:

Loss of weight in the new-born is sanctioned universally without physiologic foundation.

Postnatal loss of weight does not obtain in animals of any size.

The initial loss of weight in the new-born is the result of dehydration and semistarvation, conditions unfavorable for nutritional, physical and environmental adjustments besetting the new-born.

Past therapeutic procedures for decreasing the loss of weight in the new-born have not been altogether effective because they were not based on the physiologic needs of the new-born disturbed by birth shock.

The initial loss in weight in the new-born can be prevented by the administration of a solution consisting of 6 per cent gelatin (*p*H 6.2), 3 per cent dextrose and 0.5 per cent sodium chloride at two-hour intervals throughout the twenty-four-hour cycle immediately after birth. The gelatin hydrates blood and tissues; it raises body heat by virtue of its specific dynamic action, and it reduces the clotting time. Dextrose brings the hypoglycemia of the new-born to normal. Sodium chloride raises the initial low blood chloride and favors hydration.

The average loss of weight in new-born infants receiving the hydrating solution was 1.7 per cent, the irreducible minimum in comparison with the average loss of 7 per cent in the controls.

The characteristic clinical picture of the new-born is a result of birth shock, more effectively combated by the hydrating solution than by milk mixtures the first two or three days of life.

The total fluid intake of new-born infants properly conditioned to both breast and bottle was as much as twice that of the series receiving routine nursery care.

Preventing loss of weight in the new-born produces rapid disappearance of the so-called physiologic apathy, somnolence and stupor secondary to birth shock and the compensated acidosis universally present.

Kugelmass, I. Newton, et al.—*Preventing Loss of Weight.* American Journal of Diseases of Children, August 1933.

"No, the world has become safer for babies. Hand feeding has been robbed of its former terrors; a workable knowledge exists concerning the total and fractional food requirements of the infant; the necessity for, and the functions of, sundry vitamins and mineral salts are to a considerable degree understood, and to meet the several requirements a vast array of foodstuffs is offered for one's selection. *Yet with all these substances at command, with the factor of safety in artificial feeding greater by far than ever before, the lesson still comes home to the medical profession that no method of feeding ever devised, nor any probably that ever will be, can compare with that laid down by Dame Nature.*" [The italics are ours.—Ed.]

Lyon—History of Infant Feeding. American Journal of Diseases of Children, August 1933.

A very satisfactory and useful reading list on care of the mother before baby comes, and afterwards, has been prepared by Clara E. Hayes, M.D., of the American Child Health Association. This list of references may be obtained from the A.C.H.A., 450 Seventh Avenue, New York, N. Y. Single copies free.

Improvisation

By G. JOAN COLB, R.N.

IF Doctor Robins had ordered anything but an ice collar for little Blanche's cervical glands, Miss Patten probably would not have been at a loss. If it had been a hot water bag he wanted, she might have warmed some salt, put it into a stocking, and wrapped it around the tiny neck. Or if he had wanted a flaxseed poultice, she would have substituted oatmeal. Those were common improvisations. But of all things in this house—an ice collar! Miss Patten decided to make her little patient comfortable first and then worry.

Face, chest, arms, back, clean nightdress, legs, and the bath was finished. Into her mother's bed went Blanche. Off came the crib drawsheet, the mackintosh, the lower sheet. Over went the mattress. On went the clean bottom sheet, over it the mackintosh, and then Miss Patten stopped short.

In a flash she knew that again she was to be cheated of the worry that was supposed to make people lose weight. "I'll never be slim!" Miss Patten thought, turning to Blanche's mother.

"Do you have any adhesive tape in the house?"

"Yes. Want it?"

"Please. How about a strip of this rubber sheet? May I cut a piece off?"

"Sure. What are you gonna do?"

"If luck's with us we'll have an ice collar for the baby before I leave."

"How much are they to buy?"

"About a dollar."

"I wish I could buy one."

"Well, we can't, so we'll make one—maybe."

Snip, cut-cut, snip! From one side of the mackintosh Miss Patten cut a strip approximately nine by nine inches. She folded it in half, and cut one end V-shaped. This end and the open side she seamed securely with adhesive tape. To the tip of the V and to one side of the open top she adjusted laparotomy straps. Then Miss Patten hesitated.

"I'm smart, I am! How are we going to close this thing?"

"I don't know. What do they use on real ones?"

"Bright idea! Wait a minute."

Into the bathroom went Miss Patten, and headed directly for the enema bag, from the tubing of which she took the metal clip.

"Do you get what you want when you pray for it, Mrs. Oglin?" she asked.

"Sometimes."

By this time Mrs. Oglin was completely bewildered.

"Well, pray that the whole top of this material can crush up small enough to go through this clip. Wait, never mind praying. It's through!"

The bag was filled with ice, covered with gauze, and the strings tied.

Fifteen minutes later Mrs. Oglin watched Miss Patten pack her bag, and don her hat. At the door she put her hand on the nurse's arm.

"Saved a dollar for me, didn't you?"

"That's my job," Miss Patten laughed. "I hope the collar works. I'll be in tomorrow. 'Bye."

All this happened six months ago during which time the little ice bag, in an improved state, has travelled extensively for such a little bag. To date it has been used on a rebellious appendix, on a swollen knee, on a few hot heads, and for an axillary abscess. The adhesive worked well enough, but was too cumbersome. In a five and ten cent store (bless it!) Miss Patten found some rubber glue, which has not only improved the appearance of the collar, but has made it doubly secure. The strings have been shortened or lengthened as the specific occasion required. Miss Patten carries it in her bag—but nobody has found her out yet!

P.S. No, ice compresses didn't work. Baby Blanche objected to them in definite and deafening terms!

Cancer of the Cervix—Prevention an Educational Job

By JOSEPH COLT BLOODGOOD, M.D.

ENGLAND seems to have been the first to recognize the fact that the hopelessness of cancer was due largely to the ignorance of people. Today we are more than ever convinced that this is true in cancer of the cervix.

In 1912 the Gynecological Section of the American Medical Association requested the House of Delegates to appoint a committee to investigate the problem of educating the public about cancer of the cervix. It is rather interesting that this committee, merged with the Council of Health and Public Instruction of the American Medical Association, has accomplished much in other problems of education but very little in regard to cancer. The education of the public is absolutely vital if we are to develop this preventive work. The nurse whether in private duty or public health is surely one of the greatest agents in this vast program.

BIOPSY

Cancer never begins as cancer. First a group of normal cells is changed by some factor to abnormal cells. The factor most easily demonstrable today is chronic irritation. These abnormal cells produce a visible and palpable spot in the mucous membrane in and about the cervix. There is no difficulty in recognizing this spot under a strong light. By removing a piece of this suspected local spot and submitting it to a microscopic study, surgeons can actually determine whether or not it is malignant. This procedure is known as biopsy. Biopsy has elements of danger and must only be performed by specially trained and skilled members of the medical profession. The number of cases in which biopsy is necessary to determine whether or not the local lesion is cancerous is growing as the number of properly informed persons is growing. The danger in biopsy increases with the interval of time between the removal of the piece of tissue for microscopic study and the treatment. There is no danger unless the local condition is malignant.

There is no question that correct knowledge on the part of intelligent people of these more modern methods of medical practice will make the medical profession adopt the newer and safer methods. People must understand biopsy just as they understand other rules of medical procedure.

THE PUBLIC HEALTH NURSE'S POINT OF ATTACK

More than nine hundred Fellows of the College of Surgeons specializing in obstetrics and gynecology, and the majority of cancer specialists throughout the world, agree that cancer of the cervix in mothers may be made largely a preventable disease and almost always a curable one, *if there is proper education and treatment of the mother after the birth of her children*. Today less than ten per cent of our mothers are receiving this protection. In spite of the great value of radium as a cure for cancer of the cervix, the best that has been accomplished by the great clinics of the world, is 35% cures at the end of five years. There should be more than 90% cures in the earliest stage of cancer of the cervix discovered in these periodic pelvic examinations and diagnosed with the microscope.

Prenatal care is a tremendous factor in the health of mothers and young children. During this care nurses must instruct their patients in the value of precautionary measures during the *postnatal* period. The prenatal period is the psychological time in which to train mothers in postnatal protection. This instruction includes the establishment of confidence and the explanation of the

need of periodic pelvic examination. Every mother should have a pelvic examination within six months of the birth of her last child and subsequent examinations at intervals decided upon by a qualified physician. A tremendous amount of suffering would be saved if mothers could be made to see what a splendid precautionary measure is this periodic examination.

As I see it, the duty of the medical and nursing profession in the prevention of cancer of the cervix is fourfold:

First, we must establish confidence in place of fear, second, the public must be kept abreast of modern medical procedure, third, mothers and mothers-to-be must be instructed in the precautionary measures obtained through periodic examinations and fourth, knowledge without action is negative. Public health nurses must persuade people to act upon the knowledge in their possession.

This is the second article in the series on the subject of *Cancer* by Dr. Bloodgood. We remind our readers of Dr. Bloodgood's offer to answer any questions with regard to cancer. Dr. Bloodgood's address is: 3301 North Charles Street, Baltimore, Md.

INTERESTING ARTICLES IN THE AMERICAN JOURNAL OF NURSING, DECEMBER 1933

HOW TO USE THE INDEX

The index to the 1933 numbers of PUBLIC HEALTH NURSING appears as always in this—our December—magazine. "Reviews and Booknotes" are indexed separately at the end of the general index. It is always quickest to find an article by looking up the author's name. If the author is unknown, look under subject. In every magazine there are two sets of paging—one for the advertising section, one for the text. Numbers in the index *always refer to pages of the text* and the month may be found by referring to the first leaf of the index where a table of pages is given by month. Thus, "Hourly Appointment Service, 615" will be found to fall within "November pages 583-632."

The index is not printed separately. Extra copies of the December magazine may be purchased at thirty-five cents (25 cents to N.O.P.H.N. members.)

A Pediatrician Looks at Visiting Nursing*

By A. B. SCHWARTZ, M.D.

What are the "imponderables" in the service of a public health nurse? Dr. Schwartz tells board members.

IF you were to open the little black bag which is the simple insignia of the visiting nurse, you would find it a bit surprising that with its odds and ends she could do the many things I am going to tell you about. You have heard a recital of the year's activities of this organization. The beautiful charts and diagrams are evidence of a varied and effective year's work. There are, however, certain elements of any work involving humans that ordinates and abscissae can not express. You cannot measure the effect on artistic appreciation of a visit to an art institute, the effect on musical appreciation of attending a symphony concert, or the cultural effect of sending John or Mary to college—and in the same way, in the work of a visiting nurse association or of any organization having a social program, there are effects equally difficult to evaluate.

This appraisal of visiting nursing that I would like to give you is an effort then to measure these imponderables as a pediatrician sees them. I regard it a privilege to interpret the visiting nurse to the community, since her modesty forbids her making any display concerning her job. She has no fine buildings to show you. She goes along the highways and byways, a modern Samaritan. She does not arrive "with sounding brass nor clanging cymbals." No siren whistles announce her route, but wherever you see her entering a home, her performance is no less dramatic than if she had arrived in the shiniest chariot of the fire department. No magic talisman does visiting nursing carry into the homes it enters. Its strength as an integral part of any community social welfare program lies in the fundamental nature of its service—namely, the principle of handling the sick in relation to their surroundings.

THE FAMILY PICTURE

"It is more important," said Osler, "to know what sort of a patient a disease has than to know what sort of a disease a patient has." It is this knowledge that makes the visiting nurse's work effective. The visiting nurse knows not only the patient but she knows the family. She knows the rooms the family lives in, the neighbors, the school teacher, the policeman, the garbage collector and all the others who go towards making up the dramatis personae of a neighborhood.

That you can not successfully treat the sick without such knowledge is the most elementary teaching of both medicine and sociology. Without taking the family into consideration, medical or any other kind of aid is only another form of alms-giving. "Whether you are dealing with infants in foundling institutions," said Mary Richmond, "or children in day nurseries, or the sick in hospital wards or defectives in state institutions or prisoners in their cells or families fallen into distress or the aged in homes or the dead awaiting burial even—I care not what form of need or distress or weakness you are dealing with, you can not afford to forget the family that looms forever in the background."

ITS RELATION TO TREATMENT

Nowhere is one so impressed with the tremendous importance of this point of view as in dispensary work with chil-

*Talk before the Visiting Nursing Association, Neenah, Wisconsin, October 11, 1933.

dren. The physician's contact with the patient is necessarily a brief one. No matter how conscientious he be, to give the details of treatment in a general way, is all he can possibly do. "To size up a family," says Thornton, "means learning their store of information about the subject, their store of misinformation, and their lack of information on the subject." No physician can possibly obtain such a viewpoint in a dispensary without somebody visiting the home of the patient. On account of this, the family told to use pasteurized milk may go you one better and use certified milk, but leave the opened milk bottle on the kitchen table for flies to defeat the physician's wise instructions. On account of this, a child who is supposed to be kept in bed because of heart disease may be found climbing three flights of stairs to get to that bed. I need not enlarge on how easy it is to misinterpret a doctor's orders.*

The visiting nurse complements the physician's plan as does the stage director the playwright's manuscript, and in addition to serving as director takes on a few odd jobs for the emergency, such as scene shifter or prompter.

Patricia and Mary Louise were twins born on December the eighteenth. Ten days later they were brought to the dispensary by their parents with the request that they be hospitalized. The mother was all tired out. Each infant weighed four pounds. The physician was loath to admit them to the hospital and separate them from their mother. First in importance to these infants was breast milk which their mother had. The hospital at that time had a large number of respiratory infections, on account of which the out-patient physician was fearful of admitting the infants, because of the possibility of cross infections to which premature infants are particularly susceptible. This was explained to the parents, and the infants were sent home. The family physician was notified and a visiting nurse went out to arrange the home for premature care. She set up an improvised incubator for the smaller of the twins and gave detailed instructions as to bathing, temperature, feeding and so forth. She not only gave the instructions but also gave the first bath, took the temperatures, arranged the rooms, et cetera. The family were on County Relief. The father, out of work, was given a new job, that of acting as night nurse, offering the expressed breast milk to the babies, thus enabling the mother to get a night's rest, improving her general condition and milk supply. The visiting nurse paid daily visits to check on the progress made, and render such assistance as seemed needed from day to day. At five months of age, both infants had trebled their weight. Today they are as sturdy and normal as any infants their age.

LEARNING BY DOING

In doing its own job, this family not only achieved a normal function of family life, but gained immeasurably in the doing of it. Their daily contact with a visiting nurse was an educational project for them in hygiene unobtainable in the polite meetings of nurse and parent in a hospital ward. From the point of view of cost accounting alone, two infant lives and the education of the parents cost the community less than hospitalization.

The Committee on Social Trends and the White House Conference have commented on the serious implications of the loss of prestige of the modern home. Education has become a public concern, religious teaching a church concern, industrial training a shop concern, the recreational center of gravity has moved to the movies. Is there no function left for the family? The visiting nurse, it seems to me, is the last bulwark of an attempt to maintain one function of the family that has not yet disappeared—that of taking care of its own sick.

THE NURSE'S PRESCRIPTION

The doctor's prescription consists of

*These illustrative cases were taken from a group that received intensified home nursing follow-up in a project undertaken by the Out-Patient Department of the Milwaukee Children's Hospital in 1930-1931.

three elements: one, the active agent or drug, which may be a stimulant, a sedative, an alterative, an astringent or whatever main effect the physician desires; secondly, a synergist, whose purpose it is to intensify or modify the effect of the principal drug; lastly, the vehicle, which is the solution that dissolves these drugs, making them palatable and lending color and taste to what otherwise might be a disagreeable potion. The prescription which the visiting nurse dispenses is also compounded of three elements: intelligence its active agent, patience its synergist, and understanding its vehicle. Intelligence translates the doctor's orders into a nursing technique that meets every patient's need. In the well organized routine of your particular home, the knowledge that the visiting nurse brings to bear may not be so spectacular, but I wish that it were possible for you to see her at work in the families where the craft of visiting nursing first won its laurels. Often after writing some instructions to a dispensary patient I have wondered whether or not my written orders didn't look very much as a time table does to the average reader. And I have despaired of being able to do anything about it until I've visited the home a few days later and marvelled what "arts and curious shifts the nurse's wit devised" of this prescription.

I had no idea of its value to the medical program until I saw this nursing service away from my home town. I had not been particularly aware of its work until, on account of an interest in children, I took the opportunity when in New York City to make some home calls with the visiting nurses of the Speedwell Society there. The Speedwell Society takes care of sick infants and children in the home rather than in the hospital. I made rounds with two different visiting nurses, followed them through crowded city streets, up dark tenements and saw them at work. Since then I have seen other visiting nurses at work, going into all varieties of homes, fighting ignorance and superstition, substituting baths for goose oil, referring to the proper social agencies the particular social problems out of their province, getting defects corrected, ailments remedied, and doing it all with such simplicity that I have been exceedingly moved.

The visiting nurse in this capacity, carrying out this first element of her prescription, is the agent of the doctor and of intelligent public planning, interpreting such knowledge as social science and medicine have made available.

PATIENCE AND IMAGINATION

The mode of action of this first ingredient of the visiting nurse's prescription—intelligence—will greatly depend on what kind of synergist accompanies it, to modify its effect and deepen its value. The visiting nurse's task in the home has not to do with this illness alone, nor merely with today. In her contact with the family she has to create a relationship enabling her to do a reconstructive job. The synergist, patience, always accompanies her in the performance of her duties in every home she enters. No matter how perfect nursing services may be as a technique, it would fail in its finest purpose if it did not apply this technique with a resourceful patience. Next to the actual remedial value of the visiting nurse's service, her greatest usefulness lies in the educational value of her visits, and this usefulness in turn demands an infinite patience and imagination on her part.

The third ingredient of the visiting nurse's prescription is understanding. One can not rub shoulders daily with a family floundering in distress and not be better able to be of service to that family. She becomes a part of that family's trials and desires. They eagerly await her visits. They take her instructions willingly. They believe in her. Understanding represents the vehicle in which the active drug is dispensed. The nurse's sympathies are broadened because she sees the problem not as an isolated snapshot but as part of a panorama in which the neighborhood and the community are both concerned, and in which, though you may be unaware of it, you are one of the characters.

A GREATER INSTRUMENT FOR SOCIAL WELFARE

It is one thing to believe in the ideal illustrated by visiting nursing; it is another to believe in it sufficiently to support it generously, but these are as nothing when I think of what it takes to do this work. What Paul said of "love," should be engraved on the pins worn by these girls—"beareth all things, hopeth all things, endureth all things."

"In intellectual progress," says Whitehead, "there are three stages; the stage of romance, the stage of precision, and the stage of generalization." In your work with visiting nursing you have passed the stage of romance. The emblazoned banner and flaming spirit may still be yours, but the story of your work —a program planned, an organization efficiently meeting the needs of the community, all give evidence to your being well into the stage of precision. As technique becomes more exact, your accomplishment loses in romance unless you enlarge your function. You now enter the stage of generalization. The moving picture in which you, too, are an actor can be made truly great. With your help it will become a living thing that stirs both thought and feeling to action to make of your generous impulses a greater instrument for social welfare.

Midwives of Concordia Parish, Louisiana, demonstrating the use of silver nitrate in the eyes of the newborn, according to state law. The Parish nurse is shown at the right.

She Had to go Away

By ELIZABETH COLE

"SO this little girl's name is Pauline?" asked Tommy's teacher, Miss Dean, as she stood in his mother's doorway. "Don't you ever call her Polly?"

"Oh, my, no," emphatically answered Pauline's and Tommy's mother. "We *couldn't* do that."

"No?" the teacher questioned further. "She's such a little girl for a big name like that." And she patted the three-year-old Pauline on the head.

"Why, you see it's this way," explained the mother, "She's named for somebody very special. She's called Pauline Brown Schmitt after a nurse—Miss Pauline Brown—who used to come here."

"Sure, I remember her," broke in Tommy. "She was a pippin, wasn't she, mother?"

"Is Pauline Brown Kelley in our room named for her, too?" Miss Dean asked Tommy.

Tommy nodded.

"Yes'm, Mrs. Kelley was the first to name a child for her and would you believe it, Miss Dean, there's fourteen children in the neighborhood called after her. There's Pauline Brown Cominsky, Pauline Brown Murphy, Pauline Brown Smith, Pauline Brown Jones, Pauline Brown Bachigaloopo, Pauline Brown Pappas, Pauline Brown Stevens, Pauline Brown Isaacs, and Pauline . . . . "

Miss Dean's amused laughter interrupted Mrs. Schmitt's list. "That *is* a test of popularity. She must have been wonderful!" she exclaimed.

"You never saw her equal," Mrs. Schmitt's enthusiastic voice rang out. "A public health nurse she was, and a fiend for work. Supposed to find out cases of consumption 'n believe me she did, too. The tuberculosis society paid for her, but lor', she did everything for this neighborhood! Took all the kids to a clinic. There they punched their arms and put in something to find out if they had tuberculosis germs—tuberculin test, she called it. Showed us how to feed our families. Got us all having fresh air at night, showed old Grandpa Schmitt how to spit in a cup'n keep his germs to himself, helped to get Tony Bachigaloopo into a sunshine hospital where his legs got cured of tuberculosis—well, I can't tell you all." She stopped to take a deep breath.

"She must be wonderful," said Miss Dean. "I'd like to meet her sometime."

"There, now, that's just what you can't do—and that's the fury of it." Mrs. Schmitt's black eyes snapped. "You wouldn't believe it but she's not here any more. No, Ma'am, there wasn't any more money to pay her salary and she had to go away. Just got started to get us healthy when bang, slam! no more money. Raised it with little stickers at Christmas. Know what I mean?"

"Why, of course I do, the tuberculosis Christmas seals," replied Miss Dean.

"Well, everybody in this neighborhood was selling and buying, but I suppose some of those high-toned folks on the other side of town didn't know what a public health nurse was, nor a thing about clinics and such things. Anyhow, we lost her. Don't seem right, but we did." And Mrs. Schmitt actually wiped a tear away.

"Do you mean to say they had to let a person so necessary as that leave?"

"Yes'm, I do," was the reply. "That was a sad day when she went—everybody was crying, Tommy and all the Pauline Browns. Tommy said even the cat was crying—she'd bandaged his paw once and he never forgot it. Oh, she was the worship of this place. And the pity of it! Nobody comes round now to see how we're all getting on. Don't you suppose something can be done when they sell the seals this year so's we can get her back? Everybody can't be so poor they can't spend some pennies."

Mrs. Schmitt's voice was so sincerely

pathetic that the teacher determined she would take some strenuous steps toward making the December sale of Christmas Seals a big enough success to "get her back."

During these lean years there are far too many situations in countless neighborhoods similar to the one discovered by Miss Dean. The task of protecting children, so well started by the National Tuberculosis Association and its affiliated agencies, must be maintained if our future citizens are to be healthy. Can you resist the appeal to buy as many Christmas stickers as you can afford in order to keep such necessary work and well-loved workers as Pauline Brown in their respective communities?

OUR CONTRIBUTORS

MARY REEVES YOUNG, R.N. (Mrs. Addison), the winner of the Radio Sketch Contest, is a native of Texas. She graduated from Baylor College and the Baylor School of Nursing in Dallas. She has had postgraduate work at the George Peabody College, Nashville, Tennessee. She is at present in Houston looking for a job!

DR. JOSEPH COLT BLOODGOOD is clinical professor of surgery and director of the Garvan Experimental Laboratory, Johns Hopkins University. This is the second in Dr. Bloodgood's series of articles on cancer. We are indebted to the *Canadian Medical Association Journal* for permission to use some of Dr. Bloodgood's material previously published in Canada.

DR. ELDRED V. THIEHOFF is acting director of the Cleveland Child Health Association. Classes for expectant fathers have been held in other cities, but we believe this is the most complete and intensive plan yet tried. Success to it!

DR. A. B. SCHWARTZ, a practicing pediatrician in Milwaukee, is attending physician at the Milwaukee Children's Hospital. He was born in Georgia and had his medical training there, with interneship at Grady Hospital, Atlanta, and Massachusetts General Hospital in Boston. He has been resident physician at Children's Memorial Hospital in Chicago, war work at Fort Riley, Kansas, and Base Hospital 82, Toul, France. It was during his association at the Children's Hospital in Milwaukee that he began to realize the effective service of the visiting nurse in the out-patient program.

ELIZABETH COLE is in the publicity service of the National Tuberculosis Association. For years she has written stories for the Christmas Seal Sale. She is editor of the Journal of the Outdoor Life and editor of the monthly N.T.A. Bulletin. Her stories are excellent examples of how to popularize public health.

G. JOAN COLB, R.N., is a graduate of Beth Israel Hospital School of Nursing, New York, N. Y. She holds a B.S. degree from Teachers College, Columbia University and her experience has included hospital night supervision, private duty, and public health nursing. At present she is a staff nurse with the Metropolitan Life Insurance Company.

NORA WICKENS KENNERK (Mrs. Harry F.) is the wife of a practicing attorney, the mother of a family of eight, a member of the Federation of Farm Women, and a board member of the Red Cross Chapter—Rural Nursing Activities Committee. She lives just outside of Fort Wayne, Indiana.

Nurse-of-the-Month

ESTHER TRUDEAU

Connecticut

No, I am not related to Dr. Edward Livingston Trudeau! My mother and father are of French Canadian extraction. I am a graduate of the Holyoke Hospital Training School, Holyoke, Mass. In the third year of my hospital training, I affiliated with the Holyoke Visiting Nurse Association. For six months after my graduation in 1927 I did private duty nursing. In January, 1928, I was accepted as a staff nurse by the Hartford Visiting Nurse Association, and in 1932 was sent to Bloomfield, Connecticut, where I am now. In 1929 I attended Teachers College, Columbia, for a six weeks' course in public health.

THE VISITING NURSE COMMUTES TO THE PLANTATION

In the spring of 1932, the Hartford (Conn.) Community Chest, Inc. made it possible for the Hartford Visiting Nurse Association to furnish the town of Bloomfield, a contributor to the Chest, with a visiting nurse from its staff of fifty-three nurses. In this way the town was added to the Association's territory as a district, with the nurse who was to open this new health venture supervised by the Hartford organization. My relations with the Visiting Nurse Association are no different from those of other nurses who are stationed in districts within the city of Hartford, for I am directly responsible to a district supervisor and to the director of the organization.

The town of Bloomfield is situated northwest of Hartford in the midst of the "tobacco country" yet is within twenty minutes' ride of Hartford's shopping center. It has a population of four thousand, and covers twenty-seven square miles. The majority of the residents are of old New England stock. In contrast to these are many Polish people who live and work on the large tobacco plantations. The tobacco fields with their protecting white netting are lovely in the harvest season but discouragingly inaccessible in winter. Learning to know the special needs of those who work the fields is an interesting new experience to a nurse fresh from city pavements. For those who live in these rural sections the main industry is farming, while the people living nearer

Hartford usually work in the city and consider Hartford as their shopping center. The health problems of the latter are similar to those of city residents and can be more easily handled. The farmer and especially the plantation worker offer a different problem. Transportation facilities in the rural sections are very poor and the less fortunate must depend on the neighbor who owns a car to get to the center of town. The dirt

roads off the main highways are truly "rural" in the winter and travelling is very difficult. However, the town people are very obliging and will readily help to dig the nurse's car out of snow or mud.

The tobacco season usually lasts about four months. Young people from the various cities around are recruited in the spring by the tobacco companies for this work. Because of the poor transportation facilities, these companies build houses on the plantation for the workers to use during the tobacco season. Since the depression many of these families have stayed on the year round in these summer houses as they did not have to pay rent, and had no place to go after the season ended. Most of them had to seek aid from the town during the long idle months. The situation will be greatly altered this winter, however, for the town, county, and state health officers condemned the water supply in these houses, making it impossible for people to continue living there. They have been fortunate in not having any epidemics. Ten years ago, a transient brought in small pox, but due to the good work of the doctors in the town and the coöperation of the health officer, an epidemic was averted.

It is during the long winter months that my work progresses most. The fathers are then at home more as they no longer have work in the fields. It is mostly to them that my appeal for corrective work is made, for their coöperation usually means success

The work has consisted of a generalized program of morbidity service, including bedside nursing and tuberculosis; maternity (no delivery service); child and adult supervision; also the beginning of a social hygiene program. I try, too, to bear particularly in mind the nutritional and the mental hygiene needs of patients. A Health Station has been established where conferences are held every two weeks by appointment. The Station is in the school located in the more thickly populated section of town. I feel that this Station has helped greatly in establishing a firm hold in that section. I hope soon it will be possible to have a small space in the Fire and Community Center House to use as an office. At present all calls are handled at the main office in the city.

Bloomfield boasts a health officer, and three doctors, but no town doctor. When the town poor need one, they apply to the first selectman, who often asks the nurse to investigate these calls for him. I report the patient's condition to the doctor designated by the selectman, who visits if he feels a call is needed. This is done to help cut down town expenses. Others who cannot afford a private physician can be referred to Hartford clinics or to the Hartford Dispensary, a Community Chest member. The townspeople also may be referred if necessary to relief-giving agencies or other agencies that are Chest members.

The town employs a school nurse who devotes three and a half days a week to school work and the remainder to casework for one of the family agencies. The school nurse and I have periodic conferences on families in which we are both interested.

Every year we have a preschool round-up conducted by the State Board of Health. The school nurse and I assist the physician with the examinations. Families are notified of this round-up individually by a committee sent out by the Parent-Teachers Association. I try to do the necessary follow-up work before the children are admitted to school and send to the school nurse a report on these children, with any other information regarding the family situation that may be of use to the nurse.

My work in Bloomfield has progressed encouragingly since my first visit there. I owe a great deal of my success to the ungrudging and untiring efforts of my director and supervisors. I am fortunate in having understanding and coöperative doctors, health officer, and town officials. With the splendid support that everyone has given me I hope to be able to accomplish even more this year.

What One Community Accomplished by a Study Program *

By NORA WICKENS KENNERK

RURAL Allen County, Indiana, has enjoyed a Red Cross Nursing Service for more than thirteen years. For some time we have had four nurses, each serving a quarter of the county, and a part time supervising nurse. The nurses work in the schools, give bedside care and instruction, teach classes in schools and clubs and work with the County Health Commissioner.

Throughout these thirteen years Allen County has been fortunate in having as chairman of Rural Nursing Activities, a woman of many graces, gifted with an unusual social vision which she has developed through years of quiet, faithful devotion to local projects of health and social betterment. It is she who should be writing about the Allen County Allied Welfare Organization.

From the time the Nursing Service was established until now, we have labored—and I say *labored*—to maintain a nursing committee representative of the whole county. Our county is large—the largest in the State—and distances, transportation, and our own problems make it a continual struggle to build up and hold together a live, active committee. But our chairman refused to bow to failure and year in and year out, the monthly meetings are held regularly, the same day and hour, with a definite program, and those who do come always go away feeling repaid.

THE NURSE'S REAL JOB

During the winter of 1931-32, a study program was undertaken. Each member of the committee was assigned part of the outline and a general discussion followed her presentation of the subject. Among the topics so discussed were "How can we lengthen the arm of the public health nurse," and "Social service needs and the committee member." As a result of these discussions we realized the difference between health needs and social needs. After serving for years as committee members, it broke upon our lay minds that our nursing service was budgeted for health work and not for welfare relief. That, since we had seen our nurses doing health and welfare work all these years because the two needs were so inextricably wound together, we had been accepting it as something that should be. We now began to realize that when our nurses were responding to social service needs by securing aid from trustees, charitable groups or individuals, they were not functioning as nurses in the health field —the work for which they had received a long and expensive training, which they were really sent to us to do.

We were all agreed that no class of people are so responsive to the call of actual hunger or want as country people are, and that while the nurse was trying hither and yon to find food or clothing for one of her cases, there were in that very neighborhood, without doubt, good women who, if they could only be appealed to, would not rest in their beds till relief was forthcoming. We remembered that there were already clubs and groups doing such relief work as came to their notice, particularly Church Aid Societies, Parent-Teacher Associations and Home Economics Clubs. We felt that using the time of nurses to do such welfare work as lay workers could do was wasteful and that relief extended voluntarily by one person to his neighbor would prevent by just that much adding to the trustees' mounting tax rate.

From these considerations we advanced to the thought of inviting all

*Presented at the Indiana Regional Conference of the American Red Cross, September 29, 1933.

the clubs and groups doing any kind of social welfare work in the county to send a representative to meet with us at our next meeting. To those who came it was explained that the nursing service was not budgeted to do relief work, that the mounting social service needs were disrupting the health program, and then each group was invited to coöperate with the nurse by helping to care for the social service needs that might develop in its own neighborhood.

So cordially was the suggestion received that an organization was proposed, membership to be drawn from all the clubs, which would coördinate welfare work and help the nursing service. In May, 1932, officers were elected. The new officers working through the officers of the Parent-Teacher Association councils and Federation of Farm Women's Home Economics Clubs, asked each to name a welfare chairman. This gave the nurses a point of contact with a woman whose business it was to act for her club when any welfare need arose in thirty separate neighborhoods in the county. We called ourselves the Allied Welfare Organization.

During the winter of 1932-33, we held seven meetings. Invitations were sent to each welfare chairman and her president. We met at the Y.M.C.A. building for a noon Dutch-treat lunch, business meeting at one o'clock and home early. Upwards of twenty members attended each meeting. We are organized on the Jeffersonian theory that that government is best which governs least. Each club functions in its own way. Each is asked to make reports at our meetings of work done and methods employed. This feature has proved interesting and inspirational. The suspicious and the isolationists were disarmed by our adopting the policy that all questions would be fully discussed in meeting and their own will would rule.

When the Red Cross garment production got under way last fall, our women took the message home from our welfare meetings, each to her own club, and the work was taken up enthusiastically. In the distribution of Red Cross garments our welfare chairman performed a distinct and unique service. Red Cross garments in our county were given out by the trustee, or his authorized agents. Our trustee named each of our welfare chairmen his agent. Her card of authorization was filed with the garment production department and thereafter she was able to draw on it to fill the welfare needs of her community. She, in turn, reported back to the trustee on garments received and distributed. The trustees were very cooperative towards our welfare chairmen. Some turned over much of their investigating to our women and commended our service. Some sent their school busses to collect the women for the all-day Red Cross sewings, and furnished transportation back and forth to Fort Wayne for supplies and in other ways showed their good will and appreciation.

At the annual meeting of the County Parent-Teacher Association in April, the County welfare chairman gave the annual report of welfare work done, taken from our records. Activities listed were canning, hot lunches served, Christmas baskets, reconditioned clothing, new clothing, Red Cross sewing, comforts made, magazines redistributed. Every council shared in one or more activities and the chairman named the clubs doing the most outstanding work in each activity. This gave the members from all over the county ideas of welfare needs and possibilities.

If putting this story into words has given you the feeling that I think it is an unusual accomplishment, please do not think so. Three causes contributed to make it a very simple matter to carry out:

1. Our county women had already received valuable training in leadership and coöperation in their community clubs, Parent-Teacher Associations, Councils and Farm Federation groups.
2. There were thirteen years of earnest, unobtrusive service given by the Red Cross public health nurses.
3. There was unprecedented economic need.

These three factors combined to give us the psychological moment when such a movement almost takes care of itself.

NOTES *from the* NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING, INC.

Edited by KATHARINE TUCKER

WISH FULFILLMENT FOR THE N.O.P.H.N.

In looking for someone to fill the vacancy on the N.O.P.H.N. staff made by Mrs. Hodgson's resignation, we had various objective assets in mind, not to mention the obviously essential personality qualifications. We did not know whether we could get them all, but we think we have! Here are some of the things we wanted: a knowledge of public health nursing from the ground up; experience in a public agency, a state department of health if possible; a knowledge of the rural as well as urban field; contacts in various parts of the country and especially with the West—the farther west the better.

All of this and much more Miss Grace M. Coffman, Director of the Public Health Nursing Association of Tacoma, Washington, will bring to the N.O.P.H.N. when she joins the staff on January 1.

Miss Coffman was a public school teacher first, and then a social worker with the American Red Cross before taking up nursing. She received her Bachelor's degree, as well as her certificate course in public health nursing, at the University of Washington. Her nursing education began at the Presbyterian Hospital, Chicago, from which school of nursing she graduated. During her undergraduate nursing education she was given three months' affiliation with the Chicago V.N.A. After experience as a staff nurse with the Wheeling Visiting Nurse Service, West Virginia, under the Red Cross, she went to the State Department of Health of Idaho, where she worked for three years throughout this rural state, particularly in the field of maternity and child hygiene. And from there to Tacoma, where she has been active in state as well as local nursing affairs and organizations. Among other responsibilities she has been chairman of the Washington Committee on the Distribution of Nursing Service of the State Nurses' Association.

Grace M. Coffman, R.N.

In addition to the general public health nursing field, Miss Coffman has been particularly interested in maternity, child health and tuberculosis, which are aspects of the field needing special emphasis.

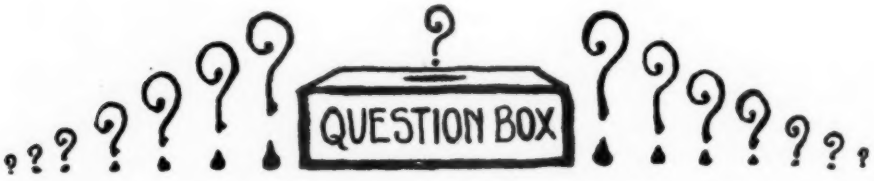
We feel that the N.O.P.H.N. is most fortunate in being able to add to its staff a public health nurse who brings such wide experience in teaching and social work as well as in public health nursing.

WITH THE STAFF IN THE FIELD

Miss Tucker. Asbury Park, N. J.—New Jersey State Organization for Public Health Nursing—Lay Section. December 8.

Miss Haupt. Charleston, S. C.—Local agencies. November 27.
Savannah, Ga.—Local agencies. November 28-29.
Jacksonville, Fla.—Local agencies. December 1-2.
St. Petersburg, Fla.—Florida Public Health Association—Annual Meeting. December 4-6.
Florida—Rural services. December 7-10.
Atlanta, Ga.—Local agencies. December 11.
Little Rock, Ark.—Consultation local agencies. December 12-13.
Springfield, Ill.—Annual Conference Illinois State Health Department. December 15.

Miss Deming. Buffalo, N. Y.—Conference New York State Health Department. December 5.
Elmira, N. Y.—Conference New York State Health Department. December 7.



Have you a question about any phase of your work? Send your question on a post-card. Address "Question Box," care of this magazine. Answers will have the approval of the National Organization for Public Health Nursing. Names of inquirers will not be used.

QUESTION:

When a nurse goes directly from her home to the home of a patient, or from the patient's home to her own, who pays the carfare?

ANSWER:

A public health nurse, like all other workers, is responsible for paying her own carfare to and from home to her place of business.

If it is the policy of the agency not to have the nurse report at the office in the morning before going to see a patient or in the evening after seeing her last case, the nurse should be responsible only for the amount of carfare that she would have to pay to get to and from her home to the office. The agency would be responsible for any additional amount.

QUESTION:

What is the longest distance a nurse may be expected to walk between cases?

ANSWER:

It is difficult to make any hard and fast rule as to the distance a nurse may be expected to walk between cases when making visits. There will always be occasions when quite long walks prove necessary even with careful planning and good transportation facilities. It seems reasonable, that under ordinary conditions, a nurse may be expected to walk to her cases when the distance between them is not more than half a mile. However, if the distance between cases seen daily is usually about one-half mile, then it would seem necessary to provide some means of transportation.

For last minute suggestions for your Christmas list, see pages 156, 157.

BOARD AND COMMITTEE MEMBERS FORUM

Edited by KATHARINE BIGGS MCKINNEY

A NEW NAME AND A NEW AIM

For the past few weeks the executive committee of the N.O.P.H.N. Board and Committee Members Section and the Magazine Committee have been debating how to make the Board Members' Forum more useful to our readers. Finally, the editor of this department, Mrs. McKinney, had a happy idea: That the board and committee members' department have a new heading—Board Members' Page—that the contents of this "page" be not limited to problems, as a "Forum" implies, nor attempt to print articles, but that it report any events or news of importance to board members and refer board members to valuable material printed either in current numbers of the magazine or elsewhere. The editors were further requested to print at least one article of special interest to board members in every number of the magazine! In January this new policy in regard to the board members' department will go into effect. We are anticipating the plan a little by referring you to two articles in this particular number which we are sure you will want to read, and reminding you that the index for the year 1933 appears in this number. A guide for its use is given on page 656.

For information: Have you wondered what all the fuss is about in record-keeping? The article on page 642 gives some fundamental reasons why the nurses can't trust their memories!

Page 635 is the N.O.P.H.N.'s interpretation of Federal Relief measures.

Page 665 describes how committee members in a rural county more efficiently met the community needs as a result of a study program.

For better understanding of the nurse's job: "A Pediatrician Looks at Visiting Nursing," page 657.

For enjoyment: "Inspiration"—Page 639, the prize-winning radio sketch.
"She Had to Go Away"—Page 661, a tale with a moral!

We remind our readers that Washington, D. C., is the meeting place of the Biennial Convention of the three national nursing organizations, and the time April 22-27, 1934. There will be a special program for board members. You will want to plan for representation of your organization in January, in order to be assured of hotel reservations. The Arrangements Committee is planning full days for us, but time is being set aside for sightseeing. Among the hundreds of attractions that the national capital offers are the White House, the Corcoran Art Gallery, the American Red Cross Buildings and Museum, the D.A.R. Buildings, Pan-American Building, Lincoln Memorial, Washington Monument, Library of Congress, Folger Shakespeare Library, Mount Vernon, Arlington and the Tomb of the Unknown Soldier, the National Cathedral, and Rock Creek Park.

As usual the N.O.P.H.N. and this magazine will have a booth among the exhibits in the Auditorium and will welcome visitors.

SCHOOL  HEALTH

A STUDY PROGRAM FOR SCHOOL NURSES

This month starts the first of a series of outlines in a study program for school nurses. The school health program, together with many health programs in the country today, is being analyzed, surveyed, and even challenged. The times call for the most thoughtful study that we can give to every phase of our school nursing activities. We hope that, as a group, scattered throughout the country yet held together by our common interest in the health of the school child, we can study our programs together this winter, perhaps coming to a better understanding of our place in the whole community health picture.

The subjects to be covered month by month in this study program* are as follows:

The Nurse and the School Health Program
The Nurse and the Classroom
The Nurse and the Home
Treatments at School
The Nurse and the Community
Records and Reports
The Nurse Herself—Preparation, Growth and Development.

THE NURSE AND THE SCHOOL HEALTH PROGRAM

The White House Conference on Child Health and Protection in its report "The School Health Program" sets a goal and gives us a guide for all school health activities in the statements:

"The health program of the schools should be definitely and fundamentally educational in nature and scope."

". . . No service should be performed in such a manner that it takes away fundamental privileges or responsibilities of the home in relation to its children."

"Any policy that does for the individual what he can do for himself leaves him more dependent and less able and willing to care for himself when the protective hand is withdrawn."

What significance do these statements have for the school nurse and her place in the health program? In the first place we might conclude from this, that if all activities should be educational, and the teacher is the one primarily concerned with teaching, she should be responsible for as many of these educational activities as can be integrated with her daily program. Let us analyze the nurse's relationship to the various groups with whom she works, in the light of these significant suggestions.

Relation to the child. Some of the common activities of the nurse in relation to the child are: Weighing; assisting physician at periodic examination; individual and classroom inspection; first aid; home visits for correction of defects.

How many of these activities are educational, or could be made so, and would prove of more value if the teacher or the child himself could perform them? Weighing—for instance. In many schools today the teacher is weighing the children regularly and keeping the growth records, or the child weighs himself, if he is old enough, and keeps his own record.

Individual and classroom inspection. Here again changes have occurred. In many schools the teachers are taking sole responsibility for morning inspection—they see the child every day and know when there is a deviation from the normal. In some schools they have gone even

*Single copies free, as they appear, to N.O.P.H.N. members, to others 10 cents.

further than that and abolished formal inspection altogether; the teacher has learned to be aware, consciously or subconsciously, of suspicious symptoms that occur throughout the day.

Relation to the Teacher. The nurse can assist the teacher by:

1. Giving her accurate scientific knowledge in regard to health and disease
2. Referring her to sound reference material on health subjects
3. Assisting her with children who present special problems, making a home visit when necessary to ascertain the family situation and its bearing on the problem.

The teacher can assist the nurse by:

1. Pointing out the health needs of individual children and the group as a whole, as she has observed them from day to day
2. Selecting children who seem to need special attention for supervision or treatment.

Relation to Parent. The nurse can assist the parent in:

1. Explaining the importance of periodic medical examination of the child preferably by the private physician
2. Interpreting the school health program to parents individually and to the P.-T.A.
3. Emphasizing parent's responsibility for correction of defects.

Relation to Community. No longer is the nurse an isolated unit in the school. She is a part of the community health program. She fulfills this part by:

1. Explaining community agencies and facilities to the school and linking them up to the school health program
2. Correlating her nursing program with other nursing and social welfare programs in the community.

"This educational program may be all right," says the nurse, "but for years I've been doing it the other way, doing everything myself—the school expects it of me—that's what I'm paid for! How am I going to change it?"

The first step would be to talk it over thoroughly with the principal, giving him such reference material as is listed below. When he is convinced, the rest will not be so difficult. Others are helping you, the educational group themselves, and the health educators.

"And what is there left for me to do?" says the nurse, "if the school and the family assume the responsibility for so many of these activities?"

It will give the nurse more time:

1. To get out in the community, find out what other agencies are doing and how her work fits in with theirs
2. To visit physicians and dentists to interpret the school health program to them and to explain their share in it as private practitioners
3. To meet with Parent-Teacher and other groups and to share in their programs
4. To perfect her records and prepare publicity material interpreting the work to the public. Experience has proved that the more people (either as individuals or as groups) know about the school nurse's work, the more likely it is to survive the pressure for economy that is testing every health service.

It may be a slow process, but in the end will lead to a much sounder and more satisfactory school nursing program.

LESSON ASSIGNMENT

List all your school nursing activities of the preceding day and analyze them according to the following criteria:

Did the child or the parent or the teacher learn something from this activity? If not, how can you change your approach or your program to bring this about? Could someone else—the teacher, for instance, or the child himself,—do this just as well or better than I?

(The editors will be glad to have school nurses send in any of the assignments that they may work out or any questions they may have. These will be referred to the advisory committee on school nursing for the School Health Section.)

REFERENCES

Palmer, George T.—"An Evaluation of School Health Procedures." School Health Research Monograph No. V. American Child Health Association, 450 Seventh Ave., N. Y.

White House Conference—"The School Health Program." Committee on the School Child, White House Conference on Child Health and Protection. The Century Company, N. Y., $2.75.

U. S. Dept. of Interior—"Health Work and Physical Education." Bulletin 1932, No. 17, Monograph No. 28, National Survey of Secondary Education, United States Department of the Interior, Office of Education, Washington, D. C.

REVIEWS AND BOOK NOTES

Edited by DOROTHY J. CARTER

OUR MOVIE MADE CHILDREN

By Henry James Forman. The Macmillan Company, New York. Price $2.50.

"Our Movie Made Children"—what a challenge to us all—parents, teachers, social workers, nurses!

Vague apprehensions have stirred us at times that perhaps the influence of movies is not all to the good, but many of us have reassured ourselves with the thought that, after all, at their best movies undoubtedly have an educational value, and at their worst, their full significance is not grasped or is soon forgotten by children.

Now comes Henry James Forman's book bringing us face to face with facts. It is the first book of its kind, that is, the first with scientific data to uphold it. The book is really a summary of studies made by the Payne Fund at the request of the Motion Picture Research Council. The studies represent four years' research on the physical, mental and moral influence of the movies on children and were made by social scientists well equipped to do the job. The children studied range in age from five years through adolescence, representing all levels of society and different sections of the country. Thus the facts given are not to be questioned lightly. It is well to remember this, as they are indeed startling—for instance:

Of the movie goers every week, twenty-eight million are minors, eleven million thirteen years or younger.

Seventy-five percent of the pictures shown deal with love, sex or crime.

The average child carries away seventy percent of what his parents do; and even the youngest retains about fifty-two percent.

The effect of bad movies is more lasting than that of good movies.

Attendance at movies makes sleep less quiet with resulting fatigue persisting for several days.

Mental attitudes are definitely affected by the movies; an attractive criminal tends to make the children sympathetic with the law breaker.

With the adolescent, standards are lowered, and the desire for easy luxury, wild parties, etc., stimulated.

So much for the indictment of the movies. On the other hand the studies show, to quote Mr. Forman, "that at their best they carry a high potential of value and quality in entertainment, in instruction, in desirable effects upon mental attitudes and ideals—second perhaps to no medium now known to us."

The book is written in an easy, informal way and without question is interesting. There is considerable repetition but this, no doubt, is meant to arouse us from our *laissez faire* attitude towards the movies. The chapter on sleep is particularly worth while for the public health nurse. The book is one that all interested in child welfare will want to read.

CHARLOTTE E. PITMAN.

HAPPY CHILDHOOD. By John E. Anderson
BUSY CHILDHOOD. By Josephine C. Foster.
HEALTHY CHILDHOOD. By Harold C. Stuart.
D. Appleton-Century Company, New York. Price $2.50 each.

In the hope of carrying the findings of the White House Conference on Child Health and Protection in popular form to parents, D. Appleton-Century Company has just published these three volumes under the editorship of Dr. John E. Anderson, Director of the Institute of Child Welfare of the University of Minnesota. These books are being issued under the group title of the Century Childhood Library.

BONFIRE

By Dorothy Canfield Fisher. Harcourt, Brace and Company, New York. Price $2.50.

At last! A good novel written about a rural nurse without any professional slips to make us squirm—at least, hardly any. Anna Craft is a registered nurse, she has had special training for her work, she understands she is doing more

than a nursing job because she has to, there is no one else. Her brother is a doctor and the whole story has a medical atmosphere which is congenial to the nurse-reader. You may not be satisfied with the ending, but you will like the novel for itself and quite envy the nurses in Vermont who have had such a very genuine and intriguing presentation of their service placed on all the bookshelves of the nation.

D. D.

OLD FRIENDS IN NEW EDITIONS

OBSTETRICAL NURSING. By Carolyn Conant Van Blarcom. Third Edition. The Macmillan Company, New York. Price $3.00.

Revised with emphasis on maternity care in the home and mental hygiene of the maternity patient. Many new illustrations included.

OBSTETRICS FOR NURSES. By Joseph B. DeLee. Tenth Edition. W. B. Saunders Company, Philadelphia. Price $2.75.

"Obstetric nursing moves forward with obstetric medicine." This tenth edition published 29 years after the first edition presents the latest advances in maternity care.

SO YOU'RE GOING TO HAVE A BABY

By Helen Washburn. Harcourt, Brace & Co., New York. Price $1.50.

Expectant mothers who like to hear the facts of maternity care discussed a little more than straight from the shoulder will enjoy this book. In true *New Yorker* style one is instructed in regard to preparations and after-care, including habit training of the child—all pretty accurate at that.

SEX EDUCATION PAMPHLETS

Five pamphlets on sex education by Dr. Thurman B. Rice have recently been made available, attractively boxed for your book shelf. The publication should be welcome to the public health nurse for the special reason that the material is arranged in pamphlet form, each one written for different age groups. "The Story of Life" for the boys and girls of ten years is simply told and interestingly illustrated. "In Training" for the boys, and "How Life Goes On and On" for the girls, are ready to place in the hands of young people of high school age. "The Age of Romance" and "The Venereal Diseases" complete the series. Dr. Rice speaks with scientific authority and also from experience and understanding of the needs of children and adolescents for this type of information. The series makes a valuable addition to the nurse's loan library. Not being bound in one volume is helpful from a teaching standpoint as the nurse has the opportunity to lend the mother that pamphlet which meets her immediate needs. Published by the American Medical Association, Chicago. Price, 25c each; set of 5, $1.00.

HELEN CHESLEY PECK.

A SOCIAL HYGIENE MOTION PICTURE

Public health nurses are urged to see the new motion picture "Damaged Lives" which has just been produced by the Weldon Pictures Corporation with the endorsement of the American Social Hygiene Association. The picture which is presented in modern story form deals with familial syphilis and is produced with extraordinary good taste, well cast, well acted and well photographed. A medical lecture carefully prepared by leading authorities follows the drama. Assurance has been given by the Weldon Pictures Corporation which is distributing the film, that the promotion and advertising of the picture will be carefully safeguarded. The film had its premier showing in Boston and is expected to have far-reaching and important results in adult mass education.

The problem of training new workers and volunteers who have been drafted in the relief program is immense. The American Red Cross has fulfilled a real need by preparing an *Introduction to Case Work and Administration of Relief*, A.R.C. 920, for the instruction and guidance of volunteers and new workers who are active in Red Cross Home Service and unemployment relief. This material sets forth in nine chapters the fundamental principles of case work and relief in simple and practicable form and includes case histories and sample records. It may be used as a study program as well as for individual and group guidance. Local Red Cross chapters may obtain this free of charge by

writing to the American National Red Cross, Washington, D. C.

THE SCHOOL LUNCH

Under "Nutrition Information" in the November *Red Cross Courier* are some excellent suggestions for school lunches for underfed children, including the organization of a School Lunch Committee with its functions.

"School Lunches Prove Their Value" and "Correlating Class Activities and Community Needs with the School Lunch" in the *Journal of Home Economics* for November describe a practical hot lunch project.

The "movie theatre" of the future may be equipped with upholstered swivel chairs and have an oculist in attendance to prescribe individual seating, according to a world-wide survey of motion pictures recently reported in *The Visual Fatigue of Motion Pictures*. Great strides have already been made in such important factors as ventilation, illumination and seating as well as in the technical art of projection. Practical suggestions for movie-goers are given. Amusement Age Publishing Company, 24 West 40th Street, New York, $1.00.

The Children's Bureau has just published a pamphlet which every public health nurse will want to read—*Children's Progress* 1833-1933 (free). In a group of well illustrated pages the whole sweep of the child welfare movement has been covered. There are some excellent talking points in the leaflet and the improvement in our efforts to promote child health can be judged at a glance. It has indeed been an amazing century for children! Board members will enjoy this leaflet as much as nurses.

FROM CURRENT PERIODICALS

Making the one-room school safe for rural children. W. W. Bauer, M.D. Nation's Schools, September.

These children—what of their future? Bailey B. Burritt. The Family, October.

The school must know the home. Knute O. Brady. Child Welfare, November.

Parent education as a mode in mental hygiene. H. M. Cushing, M.D. Mental Hygiene, October.

Survey, October Midmonthly. *Child Health Recovery.* Grace Abbott. See also *Why Mothers Die, Uncle Sam and Medical Relief,* and the *Case of the Chronic Sick.*

Survey Graphic for November. *Russia from Henry Street.* Lillian D. Wald.

A study of the maternal mortality of New York State. G. W. Kosmak, M.D. New York State Journal of Medicine, October 1.

Diabetes mellitus—problems of present day treatment. H. O. Mosenthal. Bulletin of the New York Academy of Medicine, September.

Sight-Saving Review, September. *Fighting for the Conservation of Vision.* Percy W. Cobb. See also *School Eye Clinics, Non-Shatterable Glass in Spectacles,* and *Eyes and Athletics.*

Who is incurable? A query and reply. Haven Emerson, M.D. The New York Times, Sunday, October 22. P. xx5.

PAMPHLETS AND REPRINTS

American Federation of Organizations for the Hard of Hearing. 1933 Conference Proceedings. Headquarters, 1537 35th Street, N. W., Washington, D. C. $1.00. Includes papers on "the psychology of the hard of hearing," "the hard of hearing school teacher," and the "hard of hearing child."

The Care of the Mother before the Baby Comes—and Afterwards. Two lists of references, one for parents, and one for physicians and nurses. Selected by Clara E. Hayes, M.D. Reprinted from September Child Health Bulletin. American Child Health Association, 450 Seventh Avenue, New York City. Single copies free.

Examination of the Eyes of Industrial Employees—Why and How? M. Davidson, M.D. Also Social Service with Eye Patients. Eleanor P. Brown. Each 5 cents from National Society for Prevention of Blindness, 450 Seventh Avenue, New York City.

Idleness and the Health of a Neighborhood. By Gwendolyn Hughes Berry. A social study of the Mulberry district, New York City. A.I.C.P., 105 East 22d Street, New York. Bears out the supposition that there is more than average sickness in unemployed families.

Lessons for the Expectant Mother. Prepared by Ellen D. Nicely and Caroline C. Meyers. Cleveland Child Health Association, 621 Federal Reserve Bank Building, Cleveland, Ohio. Twenty-one lessons in simple outline form, illustrated, adapted to the use of patients as well as physicians and nurses.

When Children are Injured in Industry. Publication No. 367, National Child Labor Committee, 419 Fourth Avenue, New York. 50 cents. As a result of this study seven conclusions are drawn pointing out the industrial exploitation of children.

Information for Expectant Mothers. Metropolitan Life Insurance Company, 1 Madison Avenue, New York. Scientific information in compact and convenient form.

Correction: The price of the revised edition of the Red Cross textbook on Home Hygiene and Care of the Sick is as follows: paper 75c; cloth $1.40.

NEWS NOTES

The annual Convention of the National Safety Council was held in Chicago in October. The meeting for industrial nurses which also represents the industrial nurses section of the N.O.P.H.N. was fairly well attended. Miss Adelaide Matthews, vice chairman and secretary of the Section, presided.

✣

The International Society for Crippled Children is launching a campaign of publicity against infantile paralysis. The program includes radio addresses, the use of the press, public schools and all organized community groups. In the United States from 1923-1933 there were 63,308 reported cases of poliomyelitis, in Canada only 6,378. Further information may be obtained from the Society's headquarters, Elyria, Ohio.

✣

At the meeting of the American College of Surgeons held in Chicago in October a proposal was made to extend N.R.A. codes to require employers to provide some medical attention for their workers with the report that the idea had aroused "sympathetic interest" from some of the Recovery Administration officials. The proposed health section to be added to the codes would set up a minimum of health measures to be carried out by employers, including examination before hiring new workers and X-ray machines for examinations in plants of more than 1,000 workers. Injuries which did not fall under compensation laws would be referred to physicians. The proposed medical chapter has been filed with the N.R.A. at Washington.

A testimonial dinner was given in Boston in October to Dr. George H. Bigelow, retiring Commissioner of Public Health of Massachusetts and to Dr. Henry D. Chadwick, the incoming Commissioner. The dinner was a brilliant affair, attended by 500 people and was a great tribute to the confidence and affection which is felt for Dr. Bigelow.

Addresses were presented by Dr. Kendall Emerson, Dr. Roger Lee, Dr. Washburn, of the Massachusetts General Hospital, and Mrs. Illig, chairman of the Public Health Committee of the General Federation of Women's Clubs.

✣

The Nebraska State Nurses' Association held its annual meeting in Lincoln, October 19-20. The out-of-state speakers included Mrs. Alma Scott from National Headquarters, Mrs. Mary Breckinridge, Frontier Nursing Service, Kentucky, and Miss Lona Trott, American Red Cross. There seemed to be a general feeling of inspiration throughout the entire meeting.

The newly elected officers are:

President: Myrtle Dean, Bryan Memorial Hospital, Lincoln. *First Vice-President:* Sister Olive Cullenberg, Immanuel Hospital, Omaha. *Second Vice-President:* Kate Lincoln, 660 No. 34th Street, Lincoln. *Secretary:* Helen Chamberlain, Methodist Hospital, Omaha. *Treasurer:* Avis Burdick, 2315 So. 17th Street, Lincoln. *Directors:* Jeanette Shaffer, Clarkson Hospital, Omaha; Sister Myrtle Peterson, Immanuel Hospital, Omaha; Mrs. Gladys Smits, 2440 St. Mary's Avenue, Lincoln.

Chairman of Public Health Section: Beula Wiedman, 5244 J Street, Lincoln. *Vice-Chairman:* Libbie M. Nemes. *Secretary:* Lucile Armitage, Bell Telephone Company, Omaha.

✣

The annual meeting of the National Tuberculosis Association will be held in Cincinnati, Ohio, May 14-17.

✣

Over 500 nurses attended the twenty-eighth Annual Convention of the Minnesota State Registered Nurses' Association held in St. Paul, October 18-20. October 20 was given over to the program of the S.O.P.H.N. and included a luncheon meeting and a round table discussion by the Lay Section, of which Mrs. Charles Wietoff is Chairman. The following new S.O.P.H.N. officers were elected: *President,* Agnes Leahy, St. Paul; *Vice-president,* Mrs. Gertrude Lyons, St. Paul; *Secretary,* Helen Hested, Minneapolis; *Treasurer,* Anna Nyquist, Minneapolis.

Ada Boone Coffey, R.N., extension secretary in public health nursing of the New York State Department of Health, has resigned to accept the position of chief supervising nurse on the staff of the Massachusetts Department of Public Health.

Miss Coffey assumed the duties of her new position on November 15. The Massachusetts Department of Public Health does not include a division of public health nursing but with Miss Coffey's appointment public health nursing will come under her direction.

✣

Leah M. Blaisdell has been appointed extension secretary in public health nursing on the staff of the New York State Department of Health, taking the place of Ada Boone Coffey who recently resigned. Miss Blaisdell has served as assistant to the extension secretary for the last two years and is well qualified to carry on the extensive group study program conducted by the State Department of Health.

AMERICAN PUBLIC HEALTH ASSOCIATION

Those responsible for the program of the sixty-second annual meeting of the American Public Health Association in Indianapolis October 9-12 may well be proud of their efforts. It was an exceedingly stimulating and helpful meeting.

In the meetings of the Child Hygiene Section the effect of the depression on child health, both from the physical and mental aspects, was given serious consideration. The Public Health Education Sessions brought out forcefully the need for more intensive effort in presenting to the public accurate information in regard to health and health programs.

The Public Health Nursing Section held several lively sessions in which problems vitally affecting the field today were discussed. Significant at one of these sessions were the contributions made by two representatives from the lay women's groups showing the part they were playing in the present program. Pearl McIver was elected Chairman of the Section for the coming year.

The really big thrill of the meeting was the memorial banquet held in honor of Dr. Walter Reed for his discovery of the cause of yellow fever. Among the honored guests at the speakers' table were four of the men who, as privates in the army in Cuba in 1900, volunteered to be bitten by the mosquito to test out the experiments that Major Reed was carrying on. Needless to say they received tremendous appreciation and applause.

The annual meeting next year will be held jointly with the Western Branch of the A. P. H. A. in Pasadena, California.

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